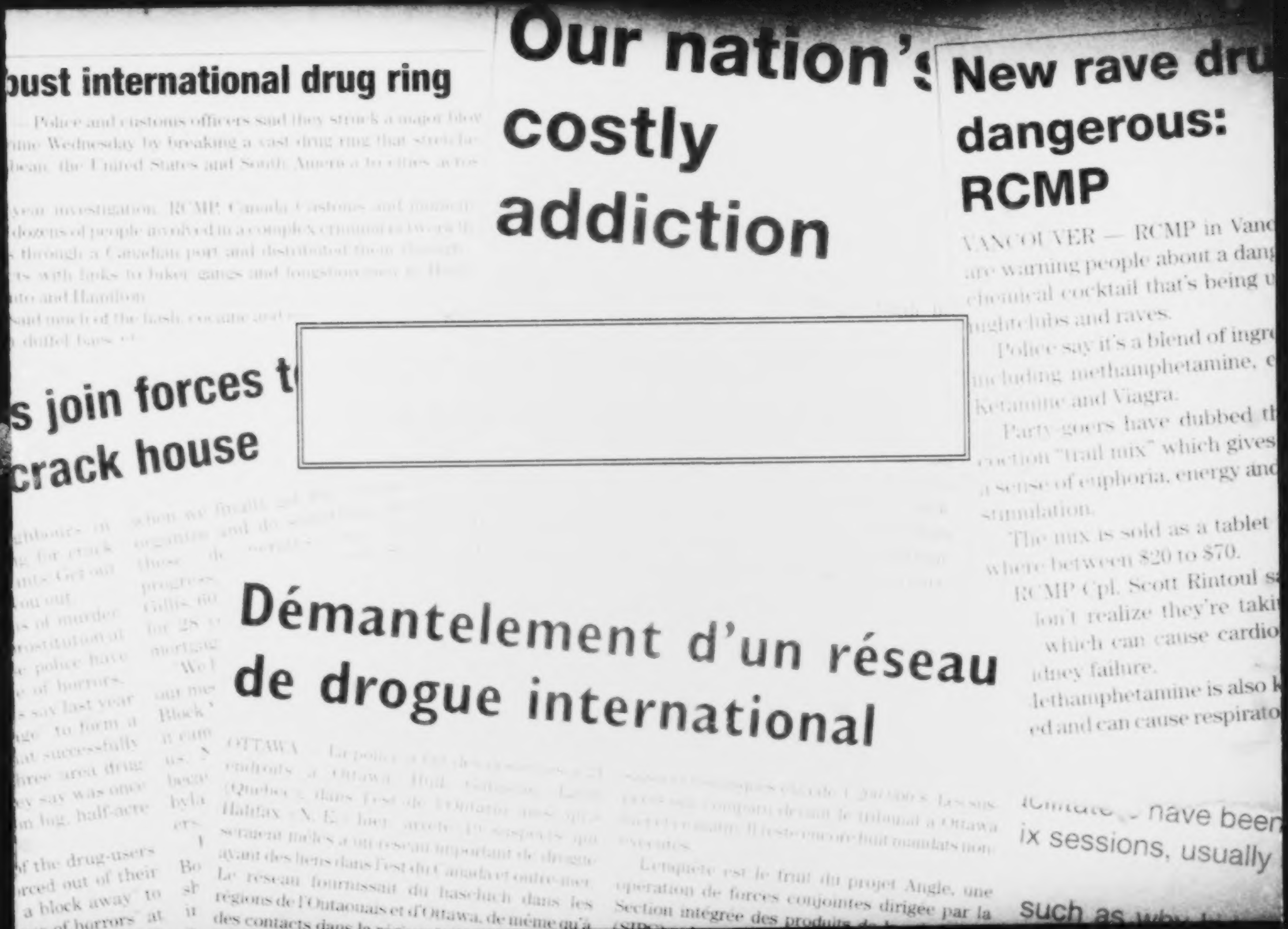
HOUSE OF COMMONS
CANADA

Policy for the New Millennium:

Working Together to Redefine Canada’s Drug Strategy



bust international drug ring

Our nation’s costly addiction

New rave dru
dangerous:
RCMP

VANCOUVER — RCMP in Vanc
are warning people about a dang
chemical cocktail that's being u
nightclubs and raves.

Police say it's a blend of ingre
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Party-goers have dubbed th
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The mix is sold as a tablet
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Démantelement d’un réseau de drogue international

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Paddy Torsney, M.P.
Chair

December 2002

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POLICY FOR THE NEW MILLENNIUM:

WORKING TOGETHER TO REDEFINE CANADA'S DRUG STRATEGY

REPORT OF THE SPECIAL COMMITTEE ON NON-MEDICAL USE OF DRUGS

Paddy Torsney, M.P.
Chair

December 2002

103-02806/

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Carol Chafe

FROM THE RESEARCH BRANCH OF THE LIBRARY OF PARLIAMENT

Chantal Collin
Marilyn Pilon

CHAIR'S FOREWORD

For too long Canadians have ignored the issue of substance use and its impact on our community. Over the past 18 months members of this special committee have been seized with this issue.

On May 17, 2001, the House of Commons created the Special Committee on Non-Medical Use of Drugs based on a motion brought forward by Randy White, M.P. (Langley—Abbottsford) and gave it a very broad mandate to study "the factors underlying or relating to the non-medical use of drugs in Canada" and to bring forward recommendations aimed at reducing "the dimensions of the problem involved in such use."

A study of this complexity can only be completed with the collaboration of a great many capable, dedicated and concerned Canadians. These individuals and organizations shared with us their passion, experience and expertise in the field of addictions and dependencies with legal and illegal drugs. On behalf of the members of the Special Committee, thank you to all of you who appeared before us or who provided us with your written submissions. Your contributions provided us with a better understanding of the depth and breadth of the problems faced by many Canadians on a daily basis and the impact on Canada's economy, our social safety network and most importantly on our families and communities.

To all those individuals who shared their personal struggles with us and allowed us to visit them in treatment centres, thank you. By opening up to total strangers and sharing your experiences, you helped us immeasurably. Each of us wishes you the very best on your journey.

A special note of thanks to our wonderful team. This special committee was blessed with excellence and dedication. The research team, composed of Marilyn Pilon and Chantal Collin, contributed their considerable expertise and writing skills to draft this report. It was no easy feat and your countless hours and weekends were very much appreciated. Congratulations to our committee clerk, Carol Chafe, your efficiency in ensuring that our work was conducted in a productive manner despite short and evolving time lines and competing schedules was remarkable. We are very grateful for the assistance and support provided by the Committee's Administrative Officer, Lise Tierney and Administrative Assistant, Melissa Mastroguiseppe. Thank you. All along, this special committee benefited from the invaluable assistance of the interpretation team, the editors, translators, console operators and others. We were under great stress, their dedication and hard work was much appreciated. The staff of the Publications Service, without whom this report would not have been possible, is very much appreciated as well.

Finally, I would like to thank my colleagues, the members of this special committee from all parties who worked so diligently on this report while attending to the work of other important committees as well as their parliamentary responsibilities. This committee was like no other. There were many obstacles in our path but we hurdled them, with humour and goodwill. This report reflects that team effort and, by and large, our non-partisan approach to the difficult issues we encountered.

We all look forward to the Government's action in response to this report. For the sake of all Canadians urgent and continued action is needed now.

Paddy Torsney, M.P.
Chair

THE SPECIAL COMMITTEE ON NON-MEDICAL USE OF DRUGS

has the honour to present its

FINAL REPORT

Pursuant to the Orders of Reference from the House of Commons of May 17, 2001, April 17, 2002, October 7, 2002 and November 19, 2002, your Committee has examined the factors underlying and relating to the non-medical use of drugs and offers the following observations and recommendations with respect to the ways and means by which the government can act, alone or in its relations with governments at other levels, in the reduction of the dimensions of the problems involved in such use.

Committees Directorate

2nd Session — 37th Parliament

ORDER OF REFERENCE

Extract from the *Journals* of the House of Commons
Monday, October 7, 2002

The House resumed consideration of the motion of Mr. Boudria (Minister of State and Leader of the Government in the House of Commons), seconded by Mr. Pagtakhan (Minister of Veterans Affairs), — That, in order to provide for the resumption and continuation of the business of the House begun in the previous Session of Parliament it is ordered:

1. That any evidence adduced by any Standing or Special Committee on any matter not reported upon in the previous Session shall be deemed to have been laid upon the Table in the present Session;

2. That during the first thirty sitting days of the present Session of Parliament, whenever a Minister of the Crown, when proposing a motion for first reading of a public bill, states that the said bill is in the same form as a bill introduced by a Minister of the Crown in the previous Session, if the Speaker is satisfied that the said bill is in the same form as at prorogation, notwithstanding Standing Order 71, the said bill shall be deemed in the current Session to have been considered and approved at all stages completed at the time of prorogation of the previous Session; (*Government Business No. 2A*)

And of the amendment of Mr. Hill (Macleod), seconded by Mrs. Skelton (Saskatoon—Rosetown—Biggar), — That motion No. 2A be amended by adding after the words "prorogation of the previous session" the following:

> "provided that Bills C-15B and C-5, introduced in the previous session, be excluded from this process.".

The House resumed consideration of the motion of Mr. Boudria (Minister of State and Leader of the Government in the House of Commons), seconded by Mr. Pagtakhan (Minister of Veterans Affairs), — That, in order to provide for the resumption and continuation of the business of the House begun in the previous Session of Parliament it is ordered:

> That a special committee of the House be appointed to consider the factors underlying or relating to the non-medical use of drugs in Canada and make recommendations with respect to the ways and means by which the government can act, alone or in its relations with governments at other levels, in the reduction of the dimensions of the problems involved in such use;
>
> That the membership of the committee be the same as the membership of the Special Committee on the Non-Medical Use of Drugs at the time of prorogation of the First Session of the present Parliament, provided that substitutions may be made from time to time, if required, in the manner provided for in Standing Order 114 (2);
>
> That the committee shall have all of the powers granted to Standing Committees in Standing Order 108; and
>
> That the committee shall present its final report no later than November 22, 2002. (*Government Business No. 2B*)

The debate continued on the motions.

The question was put on Government Business No. 2B and it was agreed to on division.

ATTEST

WILLIAM C. CORBETT
Clerk of the House

Committees Directorate

1st Session — 37th Parliament

ORDER OF REFERENCE

Extract from the *Journals* of the House of Commons
Wednesday, April 17, 2002

Pursuant to Standing Order 93, the House proceeded to the putting of the question on the motion, as amended, of Mr. Martin (Esquimalt—Juan de Fuca), seconded by Mr. Gouk (Kootenay—Boundary—Okanagan),—That Bill C-344, An Act to amend the Contraventions Act and the Controlled Drugs and Substances Act (marihuana), be not now read a second time but that the Order be discharged, the Bill withdrawn, and the subject-matter thereof referred to the Special Committee on non-medical use of drugs.

The question was put on the motion, as amended, and it was agreed to on the following division:

ATTEST

WILLIAM C. CORBETT
Clerk of the House

Committees and Parliamentary Associations Directorate

1st Session — 37th Parliament

ORDER OF REFERENCE

Extract from the *Journals* of the House of Commons
Thursday, May 17, 2001

The Order was read for the consideration of the Business of Supply.

Mr. White (Langley—Abbotsford), seconded by Mr. Benoit (Lakeland), moved,—That a special committee of the House be appointed to consider the factors underlying or relating to the non-medical use of drugs in Canada and make recommendations with respect to the ways or means by which the government can act, alone or in its relations with governments at other levels, in the reduction of the dimensions of the problem involved in such use;

> That the membership of the committee be established by the Standing Committee on Procedure and House Affairs;
>
> That the Standing Committee report the membership of the special committee to the House within five sitting days after the adoption of this motion;
>
> That substitutions may be made from time to time, if required, in the manner provided for in Standing Order 114(2);
>
> That the committee shall have all of the powers granted to Standing Committees in Standing Order 108; and
>
> That the committee shall present its final report no later that June 1, 2002.

Debate arose thereon.

Mr. Maloney (Parliamentary Secretary to the Minister of Justice and Attorney General of Canada), seconded by Mr. Lee (Parliamentary Secretary to the Leader of the Government in the House of Commons), moved the following amendment,—That the motion be amended by deleting the words "June 1" and substituting the following:

"November 1."

Debate arose thereon.

The House resumed consideration of the motion of Mr. White (Langley—Abbotsford), seconded by Mr. Benoit (Lakeland), in relation to the Business of Supply;

And of the amendment of Mr. Maloney (Parliamentary Secretary to the Minister of Justice and Attorney General of Canada), seconded by Mr. Lee (Parliamentary Secretary to the Leader of the Government in the House of Commons).

The debate continued.

The House resumed consideration of the motion of Mr. White (Langley—Abbotsford), seconded by Mr. Benoit (Lakeland), in relation to the Business of Supply;

And of the amendment of Mr. Maloney (Parliamentary Secretary to the Minister of Justice and Attorney General of Canada), seconded by Mr. Lee (Parliamentary Secretary to the Leader of the Government in the House of Commons).

The debate continued.

The question was put on the main motion, as amended, and it was agreed to.

ATTEST

WILLIAM C. CORBETT
Clerk of the House

Committees Directorate

2nd Session — 37th Parliament

ORDER OF REFERENCE

Extract from the *Journals* of the House of Commons
Tuesday, November 19, 2002

By unanimous consent, it was ordered, — That, notwithstanding the Order of reference adopted by the House on Monday, October 7, 2002, the Special Committee on Non-Medical Use of Drugs be permitted to present its final report by December 13, 2002.

ATTEST

WILLIAM C. CORBETT
Clerk of the House

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GLOSSARY OF KEY TERMS

ABUSE [ABUS]

The DSM-IV (Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association) defines substance abuse as "a maladaptive pattern of substance use, leading to clinically significant impairment or distress" as manifested by one or more of the following criteria occurring within a 12-month period: recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home; recurrent substance use in situations in which it is physically hazardous (e.g., driving or operating machinery); recurrent substance-related legal problems; and continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance. The House of Commons Special Committee on Non-Medical Use of Drugs observed that the term substance abuse is widely used and that it has varying meaning to different people. It is sometimes used to refer to any use of a substance not necessarily causing harm to health or particularly to refer to any use of an illicit substance. **In this report, the Committee prefers the term harmful use.** However, when reporting evidence or referring to published documents, the report will respect the terminology used by the authors.

ADDICTION [ACCOUTUMANCE]

According to the World Health Organization (WHO), addiction refers to the repeated use of a psychoactive substance or substances, to the extent that the user is periodically or chronically intoxicated, shows a compulsion to take the preferred substance, has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain psychoactive substances by almost any means. In general terms, an individual suffering from an addiction has developed a tolerance to a substance as well as a dependence on a substance. **In this report, the Committee prefers the term dependence.**

DEPENDENCE [DÉPENDANCE]

The DSM-IV (Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association) defines substance dependence as "a maladaptive pattern of substance use, leading to clinically significant impairment or distress" as manifested by three or more of the following criteria occurring at any time in a one-year period: tolerance; withdrawal syndrome; consuming larger amounts or over a longer period; desire or unsuccessful efforts to cut down or control substance use; spending a great deal of time in activities to obtain the substance, use the substance, or recover from its effects; giving up or reducing important social, occupational or recreational activities because of substance use; and continued use despite awareness of physical or psychological problems likely associated with substance use.

DRUG [DROGUE ET MÉDICAMENT]

A vague term of diverse meaning. According to the WHO, in medicine, a drug refers to any substance with the potential to prevent or cure disease and enhance physical or mental welfare, and in pharmacology, to any chemical agent that alters the biochemical or physiological processes of tissues or organisms. However, the term drug is often used to refer specifically to illicit psychoactive substances.

HARMFUL USE [USAGE NOCIF]

According to the WHO, harmful use refers to a pattern of psychoactive substance use that is causing damage to health: physical or mental. Harmful use commonly, but not invariably, has adverse social consequences; social consequences in themselves, however, are not sufficient to justify a diagnosis of harmful use.

ILLICIT DRUG [DROGUE ILLICITE]

A psychoactive substance, the production, sale, possession or use of which is prohibited. **In this report, the committee prefers the term illicit substance.**

LOW THRESHOLD SERVICES [SERVICES « À SEUIL BAS » OU À ACCÈS ÉLARGI]

According to the United Nations Office for Drug Control and Crime Prevention, services for drug users are known as low-threshold services when they are easily accessible by clients, and when abstinence is not a prerequisite for service provision. Often, such services work with clients on an anonymous basis. They are designed to attract future clients by offering, beside drug-related services, other services that respond to the immediate needs of clients, such as free or reasonably priced food, clothing or shelter.

METHADONE [MÉTHADONE]

A synthetic opiate drug used in maintenance therapy for those dependent on opioids.

MISUSE [MAUVAIS USAGE]

According to the WHO, substance misuse refers to the use of substance for a purpose not consistent with legal or medical guidelines, as in the non-medical use of prescription drugs. Some members of the Committee prefer the term “substance misuse” to the term “harmful use”.

PSYCHOACTIVE SUBSTANCE [SUBSTANCE PSYCHOATIVE]

A substance that, when ingested, alters mental processes such as cognition or affect. This term is most neutral and includes a whole class of substances whether they are licit or illicit. **In this report, the Committee prefers the use of the term psychoactive substance to the use of the term drug, which in common parlance usually refers to illicit substances.**

TOLERANCE [TOLÉRANCE]

A need to consume increased amounts of a substance to achieve intoxication or desired effect, or noticeably diminished effect with continued use of the same amount of a substance.

WITHDRAWAL SYNDROME [SYNDROME DE SEVRAGE]

According to the WHO, withdrawal syndrome refers to a group of symptoms of variable clustering and degree of severity, which occur on cessation, or reduction of use of a psychoactive substance that has been taken repeatedly, usually for a prolonged period and/or in high doses.

CHAPTER 1: MANDATE OF THE COMMITTEE

On May 17, 2001, the House of Commons gave the Special Committee on Non-Medical Use of Drugs a very broad mandate to study "the factors underlying or relating to the non-medical use of drugs in Canada" and to bring forward recommendations aimed at reducing "the dimensions of the problem involved in such use." The Committee subsequently adopted Terms of Reference that can be found in Appendix B of this report. On April 17, 2002, the mandate of the Committee was expanded when the House of Commons, by order of reference, added the subject matter of Private Member's Bill C-344, *An Act to amend the Contraventions Act and the Controlled Drugs and Substances Act (marihuana).*[1] Because the first session of the 37th Parliament was prorogued on September 16, 2002, the House of Commons moved to re-appoint the Special Committee on Non-Medical Use of Drugs, on October 7, 2002, with the same mandate and membership as the original. The work of this Committee marks the House of Commons' first attempt to fashion a comprehensive policy response to the legal, social and health implications of the non-medical use of drugs, since the appointment of the Le Dain Commission over 30 years ago.[2]

The creation and mandate of the Special Committee on Non-Medical Use of Drugs followed a full day of debate on a motion introduced by Randy White, M.P. (Langley—Abbotsford). A review of the Hansard Report from that day reveals the non-medical use of drugs to be an important non-partisan issue having a serious impact on all regions of Canada. Although the prevalence of marijuana use was raised in the discussion, Members of the House of Commons were clearly concerned about all illicit drugs, including heroin, cocaine, and ecstasy, as well as overdose deaths and other serious health consequences of injection drug use. Unlike the study on marijuana being conducted at that time by the Special Senate Committee on Illegal Drugs, the debates on the motion made clear that the House of Commons wished this Committee to take a broader view of the illicit drug problem and to examine all aspects of Canadian drug policy, including Canada's Drug Strategy, the effectiveness of existing prevention efforts, and what is being done to address linkages with organized crime.

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[1] Introduced on May 4, 2001 by Dr. Keith Martin, M.P. (Esquimalt—Juan de Fuca). An earlier version of the bill was given first reading on October 26, 1999: see Bill C-266, 2nd Session, 36th Parliament.

[2] The Le Dain Commission was mandated to inquire into and report on the social, economic, educational and philosophical factors relating to the non-medical use of "sedative, stimulant, tranquillizing, hallucinogenic and other psychotropic drugs or substances," as well as the state of medical knowledge respecting those drugs. See *Final Report of the Commission of Inquiry into the Non-medical Use of Drugs*, Information Canada, Ottawa, 1973, p. 4.

Since September 2001, the Committee has met with more than 200 individuals in a variety of locations, including Ottawa, Montreal, Vancouver, Abbotsford, Toronto, Burlington, Charlottetown, Halifax, Edmonton and Saskatoon. Scores of researchers, academics, treatment providers, policy experts, and volunteers from across Canada presented evidence. Many appeared in their capacity as individuals, while others represented advocacy groups, law enforcement organizations, government departments, and non-governmental agencies. The names of persons who appeared before the Committee can be found in Appendix C of this report. The Committee also received written submissions from many groups and individuals whose names are listed in Appendix D of this report. Finally, the Committee visited treatment centres and low-threshold services across the country, inspected some of the busiest border control facilities in Canada, and traveled to the United States and Europe in order to consult with addictions experts, research institutes, politicians, law enforcement agencies, and senior government officials, and to experience first-hand, the impact of some of their more innovative treatment regimes. In addition to encouraging Members of the House of Commons to hold public consultations within their own ridings and report on their findings, the Committee also invited provincial and territorial Ministers of Health to participate in its study, either in person or by written submission.

Although this report specifically addresses the most egregious matters encountered, Committee members agree that the non-medical use of drugs in Canada is a pervasive and growing problem that must be answered with sustained, broad-based, adequately funded policy initiatives that can be applied to all substances of abuse, regardless of their source, effect or legal status. Consequently, in addition to making specific recommendations, this report sets out a plan for achieving a renewed federal drug strategy that draws on the considerable body of knowledge and expertise already existing in Canada, while proposing extensive improvements in clinical and social research, program evaluation, data collection, and resource allocation in order to revitalize the federal government's role in responding to the challenges posed by the non-medical use of drugs in Canada.

During its meetings and visits, the Special Committee on Non-Medical Use of Drugs heard evidence relating to a host of licit and illicit substances, as well as the people most affected by them. Three decades after the final report of the Le Dain Commission, the Committee was shocked and saddened to learn that the associated health and social devastation continues, to the extent that substance abuse is linked to one in five deaths in Canada.[3]

---

[3] Eric Single, Testimony before the House of Commons Special Committee on Non-Medical Use of Drugs (hereinafter called the Committee), November 7, 2001.

> *When you know at the street level that there is not enough treatment you get angry at seeing money being spent to punish those who can't get into treatment. When you see staggering amounts of money being spent for treatments that either don't work or are geared to control rather than help, you want to scream out your frustrations. When you see people making money off of the misery of the addicted and nothing has changed you want answers.*[4]

It is the Committee's fervent hope that its work will make a difference to those at the street level.

---

[4] Thia Walter, Submission to the Committee, December 5, 2001.

CHAPTER 2: USE AND HARMFUL USE OF SUBSTANCES, AND DEPENDENCE IN CANADA

> *As a physician, I am confronted daily with the severe health consequences of drug use, from the heroin junkie in withdrawal, to the crack smoker coming off a 72-hour binge, to the battered teenage girl who just had a bad date. There is something terribly wrong. I am convinced that it can't be only the drugs. There is something about our response to drug use that makes a bad situation much worse than it has to be.*[5]

> *Illicit drugs are an important issue for Canada because of their significant negative impact. The economic cost is estimated at $5 billion annually, including health care, lost productivity, property crime, and enforcement. Each year, more than 50,000 individuals are charged with drug offences, resulting in more than 400,000 court appearances. And finally, the sale of illicit drugs is a major source of funding for organized crime and for terrorism.*[6]

1. WHAT DO WE KNOW ABOUT THE PREVALENCE OF USE AND HARMFUL USE OF SUBSTANCES, AND DEPENDENCE?

The use of psychoactive substances appears to be an almost universal phenomenon, which is complex and subject to emotional debates. Reducing the supply of and demand for illicit substances are challenges faced by almost every country. Harmful use of substances (mostly of psychoactive substances including alcohol) has been related to a wide variety of social and health issues, including HIV/AIDS, Hepatitis C, homelessness, family violence, prostitution, sexual exploitation, delinquency, crime, and child abuse and neglect. Overall, the Committee believes that the harmful use of substances, and dependence, are primarily public health issues that must be addressed within a public health framework.

Alcohol and tobacco are the most widely used psychoactive substances throughout the world. Current levels and patterns of use of these substances engender harm to health and costs to society that greatly exceed the harm from the use of illicit substances. However, the wide use of such substances would mandate in-depth individual studies beyond the scope of the work of the present Committee. The Committee thus decided to concentrate its efforts on the use of illicit substances and the non-medical use of prescription drugs.

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[5] Dr. Mark Tyndall, Director of Epidemiology, B.C. Centre for Excellence, University of British Columbia, Testimony before the Committee, December 3, 2001.

[6] Opening statement of Michael McLaughlin, Deputy Auditor General, before the Committee, February 6, 2002.

It is important to note at the outset that most people who report having used drugs at least once in their lifetime have done so either experimentally or have used intermittently when they were adolescents and young adults. A relatively small percentage will continue to use drugs regularly later in life (around 20% and even less for illicit drugs) but more than 75% will continue using alcohol.[7] An even smaller percentage will use substances in a pattern that is causing damage to their health or become dependent on substances.

Notwithstanding the fact that a small percentage of the population consumes psychoactive substances, we must not ignore that use is increasing and so is the potential for harmful use and dependence with devastating consequences for the users and society as a whole.

According to a 2002 United Nations report, cannabis was the illicit substance most widely used throughout the world in the late 1990s (some 147 million people or 3.5% of the global population aged 15 and above), followed by amphetamines (33 million people used methamphetamine and amphetamine, and 7 million used ecstasy), cocaine (13 million people), and opiates (some 13 million people, of whom about 9 million consumed heroin). The report also showed that: substance abuse is substantially more common among men than among women (particularly with regard to the abuse of heroin, crack-cocaine or methamphetamine); there is a correlation between unemployment and prevalence of substance use in many countries; and prevalence of illicit drug use is higher among younger age groups (18-25 years of age) in practically all countries.[8] However, the harmful use of substances is not specific to any age group, class, ethnic group or gender.

Student surveys show that more and more adolescents are using illicit substances, mostly cannabis. Lifetime prevalence use of cannabis among youth is very high. According to the United Nations report, 42.8% of 10th graders in the United States and 23% of 15 and 16 year old students in Europe reported having used cannabis at least once. The report further indicates that lifetime prevalence of all drug use (including tranquilizers and inhalants) among 15 and 16 year old students is higher in the United States (46.2%) than in Europe (25.1%).[9]

Substance use has become part of the lifestyle of many young people throughout the world, and young Canadians are no exception. According to a World Health Organization cross-national study on health behaviour in school-aged children conducted in Canada by Queen's University, alcohol, tobacco and illicit substances (mostly cannabis) are widely used by youth. "[By] grade 10 over 90% of young people had tried alcohol." Astoundingly, two-thirds (68%) of Grade 6 students had also tried alcohol. The percentage of grade 10 boys who reported drinking beer at least once a week went down from 30% in 1990 to 18% in 1998. Among girls, the reported use went down from 19% to 10% between 1990 and 1998. The study further shows a "sharp increase in hashish/marijuana use between 1994 and 1998. Interestingly this was associated with lower use of beer which may suggest a shift in substance use. Certainly marijuana is much more widely available at the present time than in the past and the cost is relatively low".[10] Forty-two percent of Grade 10 students reported having used marijuana three or more times in 1998 compared to 25% in 1990. Use of marijuana by Grade 8 students went up from approximately 10% in 1990 to 19% in 1998. Cocaine use by Grade 10 students nearly doubled between 1994 and 1998, going up from 3% to 5.5%. Adolescents usually use substances in the company of friends who also smoke, drink or use illicit drugs.[11]

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[7] European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), *Drugnet* Europe, Bimonthly Newsletter of the EMCDDA, No. 26, July-August 2002.

[8] United Nations Office for Drug Control and Crime Prevention, *Global Illicit Drug Trends 2002*, New York, 2002, p. 213-14.

[9] Ibid., p. 216.

Why has there been such a substantial increase in consumption? An analysis of the 1977-1999 Ontario Student Drug Use Surveys suggest that increasing rates of use correlates with young people's weakening perceptions of risk of harm in drug use, weakening moral disapproval of drug use, and increasing perceived availability of drugs.[12]

In Canada, national data on the prevalence of substance use among the general population 15 years of age and older was collected in the 1994 Canada's Alcohol and Other Drugs Survey.[13] The most commonly used illicit substance was cannabis with 7.4% of the respondents reporting use in the last 12 months (28.2% reporting lifetime use),[14] followed by 1.1% reporting current use of LSD, speed or heroin and less than 1% reporting current use of cocaine.[15] The 1994 survey did not assess the prevalence of ecstasy use but provincial data suggest that it is as prevalent in Canada as in other countries. Where injection drug use is concerned, recent studies estimate that there are between 90,000 and 125,000 injection drug users in Canada, of whom 25,000 inject steroids. The most commonly injected drugs are cocaine and heroin.

There is very limited data on the misuse of prescription drugs in Canada but the Committee has observed that such misuse is a concern throughout the country. A recent report of the Canadian Institute for Health Information indicates that "millions of Canadians take medications daily" and that "about 65% of Canadians 12 and older said they had taken painkillers in the last month"[16]; 5% had taken sleeping pills and tranquilizers and 4% antidepressants.[17] The diversion of prescribed stimulants (e.g., Ritalin) is a concern among adolescents. A recent study of students in the Atlantic provinces concluded "[o]f the 5.3% or students who reported medical use of stimulants in the 12 months before the survey, 14.7% reported having given some of their medication, 7.3% having sold some of their medication, 4.3% having experienced theft and 3.0% having been forced to give up some of their medication."[18]

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[10] Health Canada, *Trends in the Health of Canadian Youth*, Ottawa, 1999, Chapter 10, p. 98.

[11] Ibid., p. 98-99.

[12] Edward M. Adlaf, Angela Paglia and Frank J. Ivis, *Drug Use Among Ontario Students, 1977-1999: Findings from the OSDUS*, Centre for Addiction and Mental Health Research Document Series No. 5, available online at www.camh.net/addiction/ont_study_drug_use.html.

[13] Health Canada, *Canada's Alcohol and Other Drugs Survey 1994: A Discussion of the Findings*, 1997.

[14] Includes "one-time only" use.

[15] Health Canada, *Canada's Alcohol and Other Drugs Survey 1994: A Discussion of the Findings*, 1997, p. 63-64.

[16] Painkillers ranging from aspirin to morphine.

With respect to alcohol and tobacco, the 2000-2001 Canadian Community Health Survey estimated that 21.5% of Canadians aged 12 and over were daily smokers and 20.1% were heavy alcohol drinkers (reporting drinking 5 or more drinks on one occasion, twelve or more times in the past year). Where young people ages 15 to 19 are concerned, the Survey estimated that 35.2% of males and 28.8% of females were drinking 5 or more drinks on one occasion, twelve or more times a year, and that 18.3% were daily smokers.[19]

Not enough is known of the economic costs associated with the use and harmful use of substances. In Canada, the most recent information on the health, social and economic costs associated with the use of psychoactive substances dates back to the 1996 publication by the Canadian Centre on Substance Abuse, *The Costs of Substance Abuse in Canada*, which analyzed data collected in 1992. The study estimated that substance abuse was costing more than $18.45 billion in Canada, 40.8% of which was attributed to alcohol. Tobacco related costs accounted for $9.56 billion, or more than half (51.8%) of the total cost of substance abuse. The economic costs of illicit drugs were estimated at $1.37 billion, of which approximately $823 million was attributed to lost productivity due to illness and premature death, and approximately $400 million was spent on law enforcement. Direct health care costs due to illicit drugs were estimated at $88 million.[20] In the 2001 Report of the Auditor General, the economic costs due to illicit substances, including health care, lost productivity, property crime, and enforcement were estimated to exceed $5 billion annually.[21] More specifically, a 1996-1997 study[22] of a cohort of 114 untreated illicit opiate users in Toronto concluded that the 1996 annual social cost generated by this sample was $5.086 million.[23] These costs were explained mostly by crime victimization (44.6%) and law enforcement (42.4%), followed by productivity losses (7.0%), and health care costs (6.1%).[24]

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[17] Canadian Institute for Health Information, *Health Care in Canada*, Statistics Canada, 2002, available online at secure.cihi.ca/cihiweb/products/HR2002eng.pdf.

[18] Christiane Poulin, "Medical and non-medical stimulant use among adolescents: from sanctioned to unsanctioned use", *Canadian Medical Association Journal*, 165 (8): 1, 2001, p. 39-44.

[19] *Statistics Canada, Canadian Community Health Survey, 2000/01, available online at* www.statcan.ca/english/ *freepub/82-221-XIE/0050X2/tables/html/2155.htm.*

[20] Eric Single et al. *The Costs of Substance Abuse in Canada*, Canadian Centre on Substance Abuse, 1996.

[21] Office of the Auditor General of Canada, *2001 Report of the Auditor General*, Chapter 11 — llicit Drugs: The Federal Government's Role, 2001.

[22] R. Wall et al., "The social cost of untreated opiate use," *Journal of Urban Health*, 77, 2001, p. 688-722.

Finally, activities related to supply reduction result in ever-increasing burdens on the law enforcement and control system. In 2001, there were more than 90,000 incidents of impaired driving reported by law enforcement agencies with about 71,000 people charged. There were 91,920 incidents related to the *Controlled Drugs and Substances Act* reported by police in Canada that same year. Cannabis offences accounted for approximately three-quarters of all drug-related offences.[25] The phenomenon of residential marijuana growing operations is a particular concern. "There has been an observed increase in organized and sophisticated multi-plant profit-oriented operations. The illicit profits generated are enormous and the involvement of organized crime is integral to these operations."[26]

> *The huge growth of hydroponic marijuana sites in the southwest Ontario region presents a wide spectrum of policing issues. In fact, this is a country-wide or North America-wide situation. Police officers are required to be familiar with specialized equipment and the handling practices. The equipment and its upkeep is expensive, and the sheer volume of sites is a considerable drain on policing resources and a very significant safety hazard to all the emergency providers, police and all those who respond, including hydro personnel.*
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> *Hydroponic marijuana prosecutions result in sentences in the range of six months to one year, hardly a deterrent to the organized criminal groups that can bring in $400,000 per year from 400 marijuana plants. It is also believed in the policing community that the funds derived from these operations are being used to fund other drug importation, such as that of heroin, MDA, and ecstasy, and other criminal enterprises. A large majority, over 80%, of the criminal organizations are involved in drug trafficking. Illicit drugs are the staple commodity of organized crime enterprises.*[27]

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[23] Albeit it is risky to generalize these findings to the rest of the population of illicit opioid users, the researchers noted that the majority of their respondents were recruited within the context of needle exchanges and social service agencies and that to the extent that these users were better informed about health risks and better motivated to access health and social services, "their social costs may be lower compared to otherwise similar but more isolated individuals."

[24] Crime victimization costs include out-of-pocket expenses, compensation for pain and suffering, productivity losses and health care. Law enforcement costs include police, courts and corrections. Productivity losses calculate morbidity and mortality costs. Health care costs include inpatient care, emergency care, outpatient care, substance abuse treatment, medical care, ambulance services and pharmaceuticals.

[25] Josée Savoie, "Crime Statistics in Canada, 2001," *Juristat*, Statistics Canada, Canadian Centre for Justice Statistics, Catalogue no. 85-002-XIE, Vol. 22, no. 6, p. 10-11. The number of incidents are based on the Uniform Crime Reporting Survey, which reflects only the most serious offence committed at the time of a criminal incident. Consequently, if a criminal incident involves a robbery and a drug possession offence, only the robbery will be entered in the database.

[26] Criminal Intelligence Service Canada, Special Report — Operations GREENSWEEP I & II, 2002, available online at www.cisc.gc.ca/AnnualReport2002/Cisc2002/greensweep2002.html.

[27] Chief Julian Fantino, Toronto Police Services, Testimony before the Committee, February 18, 2002.

2. ILLICIT SUBSTANCES[28]

This section will give a brief description of the main illicit substances under the *Controlled Drugs and Substances Act* (1996, c. 19), their sought-after and short-term effects,[29] long-term effects and a very broad idea of the prevalence of their use and/or harmful use. These substances fall into three main groups: central nervous system depressants (e.g., heroin), stimulants (e.g., cocaine) and hallucinogens (e.g., LSD). Cannabis is in a class of its own as it has depressant effects and may also cause hallucinations on rare occasions when consumed in very large doses. It is important to note that the psychoactive effects and other consequences of substances on users are determined by a variety of factors: the concentration of psychoactive agents; mode of intake; circumstances in which the substance is taken; mental state of the user; expected effects; history of substance use; individual physiology and whether the substance is used in combination with other mood-altering substances.

What are the main substances used by persons treated for harmful use, and dependence, in North America and some countries of Europe? Among those in treatment, opiates and cocaine appear to be the primary substances for which people sought treatment followed by cannabis and amphetamines. In Canada, information dating back to 1995-1996 shows that 63.3% of users were treated for problems with cocaine-type drugs (including cocaine, crack and basuco[30]), 45.3% for heroin, 5.3% for amphetamines and 18.3% for cannabis. In 1999, in the United States, 27.7% were treated for problems related to heroin use, 26.8% for abuse of cocaine-type drugs, 26.3% for cannabis and 8.5% for amphetamines.[31] In 1999, in Germany, 64.7% of individuals were treated for opiates, 7.7% for cocaine, and 22.2% for cannabis. That same year in the Netherlands, 63.2% were treated for opiates, 21.2% for cocaine, 10% for cannabis and 2.6% for amphetamines. In 1998, in Sweden, 32% were treated for opiates and 7% for cannabis.

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[28] The United Nations Office for Drug Control and Crime Prevention's document *Terminology and Information on Drugs* prepared by the Scientific Section (Laboratory) Policy Development and Analysis Branch, Division for Operations and Analysis, October 1998, is the main source of information on various substances described in this section. The document is available online at www.undcp.org/odccp/report_1998-10-01_1.html.

[29] Effects produced by a single dose or a short period of continuous use of a substance.

[30] Basuco (from the Spanish "base de coca") is a cheap impure form of cocaine that "is especially toxic because it contains kerosene, sulphuric acid and other poisonous chemicals used in extracting cocaine from the coca leaf. Basuco causes an even stronger sense of euphoria than inhaling glue and thus causes a more intense need for the user to continually seek a "fix"." Press Release WHO/35 — 21 April 1994.

[31] United Nations Office for Drug Control and Crime Prevention, *Global Illicit Drug Trends 2002*, New York, 2002, p. 275-78.

(a) Cocaine

> *... the HIV epidemic in Vancouver is driven mainly by injection cocaine use. Although poly-drug use, including heroin, crack cocaine, marijuana, alcohol, and a range of other drugs, is widespread, it is the pattern of injectable cocaine use that poses the highest risk of HIV and hepatitis transmission. Cocaine is also associated with a high incidence of injection-related infections.*[32]

Cocaine and crack (a freebase form of cocaine) are stimulants that produce a quick temporary increase of energy by stimulating the central nervous system. Cocaine is prepared from coca leaves or can also be synthesized in a laboratory. It is usually sniffed, snorted, smoked or injected. Crack can be injected or smoked (freebasing).

Sought-after effects of cocaine are:

- feelings of physical and mental well-being, exhilaration and euphoria;
- increased alertness and energy;
- decreased appetite; and
- diminished sleep.

Short-term effects of cocaine include:

- rapid breathing and heart rate;
- increased blood pressure and body temperature; and
- bizarre, erratic and sometimes violent behaviour.

Higher doses of cocaine may cause:

- hallucinations;
- talkativeness;
- a sense of power and superiority;
- restlessness, hyperexcitability and irritability;
- panic; and
- paranoid thoughts.

Excessive doses of cocaine may lead to:

- convulsions and seizures;
- stroke;
- cerebral haemorrhage; or
- heart failure.

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[32] Dr. Mark Tyndall, Director of Epidemiology, B.C. Centre for Excellence, University of British Columbia, Testimony before the Committee, December 3, 2001.

Long-term effects of cocaine vary with the mode of intake and may include:

- destruction of the tissues in the nose;
- respiratory problems;
- infectious diseases;
- abscesses;
- malnutrition;
- paranoid psychosis;
- disorientation, apathy and confused exhaustion;
- depression; and
- death from respiratory failure, which may occur during the "crash."[33]

Chronic excessive use of cocaine causes tolerance and may lead to strong psychological dependence. Cocaine is the second most common substance for which users seek treatment throughout the world.[34] In Canada, a significant proportion of injection drug users are now injecting cocaine, increasing considerably the risk of HIV seroconversion, of contracting Hepatitis C, and of overdose death. This situation is particularly evident in Vancouver and other large urban centres.[35] According to the 2002 United Nations report on global illicit drug trends, 70% of all reported cocaine use takes place in the Americas and some 22% in Europe (mostly in Western Europe) globally affecting 13.4 million people in the late 1990s.[36] However, cocaine use across Europe is increasing and is becoming far more widespread than opiate use, even though opiates remain the primary substance for which users seek treatment.[37]

(b) Heroin and other opioid analgesics

> *During the ten years from 1991 to 2000, there were 2,748 illicit drug deaths in the province of British Columbia. Most of these deaths occurred within the city of Vancouver. ... In unpublished work on 990 deaths from three years — 1997 to 1999 — of coroners' files of B.C. illicit drug deaths, 74% of these deaths were found to involve opiates, while cocaine caused or contributed to 49%. Ethanol was*

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[33] The rush of cocaine depletes the brain's supply of the neurotransmitters serotonin, norepinephrine and dopamine and blocks their reuptake process. The crash refers to a period of depression, irritability and anxiety that follows the short-lived euphoric high induced by cocaine, as the feel good natural chemicals serotonin, norepinephrine and dopamine have been depleted. This crash lasts until the brain begins to manufacture these chemicals once again.

[34] United Nations Office for Drug Control and Crime Prevention, *Global Illicit Drug Trends 2002*, New York, 2002, p. 244.

[35] Health Canada, *Cocaine Use. Recommendations in Treatment and Rehabilitation*, prepared for Canada's Drug Strategy Division by G. Ron Norton, Michael Weinrath and Michel Bonin, University of Winnipeg, 2000, p. 1.

[36] United Nations Office for Drug Control and Crime Prevention, *Global Illicit Drug Trends 2002*, New York, 2002, p. 244.

[37] Ibid., p. 251.

> *a contributing factor in 17% of illicit drug deaths during the same time period. Methadone caused or contributed to 17 deaths, or 2% of the total, from 1997 to 1999.*[38]

Heroin is part of the opium family. It is a semi-synthetic opiate synthesized from morphine, like hydromorphone (Dilaudid) and oxycodone (found in Percodan and Percocet). Methadone is also a synthetic opioid currently being used to treat heroin addiction. Heroin can be injected, inhaled (chasing the dragon), smoked, sniffed or snorted. Other means of use include eating or stuffing (squirting heroin solution into the rectum with a syringe barrel). Poly-drug use is common among opiate users.

Opiates have numerous important medical uses as painkillers (e.g., morphine, MS-Contin); cough suppressants (e.g., codeine). They are also used to treat diarrhoea and are currently under investigation for the maintenance therapy of heroin addicts. The use of opioids to treat severe pain should not be hindered by concerns of their potential to cause dependence. Prescription use should always be based on a medical evaluation balancing adequate pain relief with other possible side effects.

Sought-after effects of opiates include:

- reducing tension, anxiety and depression;
- inducing euphoria, warmth, contentment;
- relaxed detachment from emotional as well as physical distress; and
- relief from pain.

Short-term effects of opiates are:

- nausea and vomiting;
- drowsiness;
- inability to concentrate;
- apathy; and
- decreased physical activity.

Regular use of opioids causes psychological and physical dependence and withdrawal from heroin engenders severe physical symptoms. Overdose deaths are common.

> *My experience in Vancouver has been that I've been working with the city for 14 years, since 1987, and 10 of those years from 1987 to 1997 were at the Carnegie Centre at the corner of Main and Hastings. From the corner of Main and*

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[38] Dr. Mark McLean, Associate Medical Health Officer, Vancouver/Richmond Health Board, Testimony before the Committee, December 4, 2001.

> *Hastings at the Carnegie Centre I had a very good vantage point to witness what was clearly a public health disaster, one for which our city has become known around the world.*
>
> *[...]*
>
> *We watched as Vince Cain, the chief coroner, released a report — in September 1994, I believe — calling for action. That was the year close to 400 people died in British Columbia of illicit-drug overdose deaths. We watched throughout the nineties, and at the Carnegie Centre we began to do more and more memorial services. We are the community centre for the neighbourhood, and we were doing memorial services every couple of weeks for people who had overdosed and died.*[39]

Long-term effects of opiates vary with the mode of intake and may include:

- infectious diseases;
- constipation;
- abscesses;
- respiratory problems;
- malnutrition;
- menstrual irregularity; and
- chronic sedation and apathy, leading to self-neglect.

Excessive use of opiates causes serious health problems worldwide reflected in high rates of mortality and morbidity. As well, it is associated with mental health disorders, socio-economic dysfunction, and criminality. It is estimated that 0.3% of the global population aged 15 and above were using opiates in the late 1990s. Heroin abuse was estimated to affect 0.2% of the population.[40] Opiate injectors are particularly vulnerable to the most serious drug-related harms to health (e.g., overdoses) and life-threatening infectious diseases, such as HIV, AIDS, Hepatitis B and C and tuberculosis. Opiates, mainly heroin, account for more than 70% of all requests for treatment in Europe.[41] However, most of the Western European countries are observing stabilization or a decrease in the abuse of heroin. In the United States, the use of heroin was reported to be stable in 2000, affecting some 0.5% of the population aged 12 and above, and representing 30.3% of all admissions to treatment, excluding alcohol, in 1999.[42] In Canada, studies published in 1997-1998 estimated that 60,000 to 100,000 individuals or some 0.3% of the population were illicit opiate users.[43] All these percentages likely underestimate the number of opiate users, as this population is largely marginalized, stigmatized and difficult to reach through general population surveys.

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[39] Donald MacPherson, Drug Policy Coordinator, Social Planning Department, City of Vancouver, Testimony before the Committee, December 4, 2001.

[40] United Nations Office for Drug Control and Crime Prevention, *Global Illicit Drug Trends 2002*, New York, 2002, p. 223-24.

[41] Ibid., p. 230.

[42] Ibid., p. 241.

In Canada, a 1996-1998 study of a cohort of 114 untreated illicit opiate users in Toronto indicated that these individuals were regular poly-drug users: alcohol (70.2%), crack/cocaine (57.9%), and benzodiazepine (60.5%). Many had serious health problems (54.4%), had no permanent housing (51.8%), had multiple overdose experiences in the last twelve months (50%), had visited an emergency room for a drug-related problem (62.3%), were involved in illegal activities for income generation (67.5%), were arrested for a drug or property offence in the last year (51.4%), and were incarcerated (42.1%).[44]

(c) Amphetamine-type stimulants

Amphetamine-type stimulants are a family of artificial stimulants that include substances commonly known as "uppers," "bennies" and "pep pills." Methamphetamine is a derivative of amphetamine and is known on the streets as speed, crystal, crank or ice. These substances may be taken orally, sniffed or injected. They activate, enhance or increase activity of the central nervous system.

Sought-after effects of amphetamine-type stimulants are similar to cocaine and include:

- feelings of physical and mental well-being, exhilaration and euphoria;
- increased alertness and energy; and
- improved performance at manual or intellectual tasks.

Short-term effects of amphetamine-type stimulants are:

- loss of appetite;
- faster breathing;
- increased heart rate and blood pressure;
- increased body temperature and sweating;
- dilation of pupils; and
- bizarre, erratic and sometimes violent behaviour.

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[43] R. Remis et al., Consortium to characterize injection drug users in Canada, Montreal, Toronto and Vancouver, Final report, Toronto, 1998 and B. Fischer, and J. Rehm, "The case for a heroin substitution treatment trial in Canada," *Canadian Journal of Public Health*, 88, 1997, p. 367-70.

[44] B. Fischer, W. Medved, L. Gliksman, and J. Rehm, "Illicit Opiates in Toronto: A Profile of Current Users," *Addiction Research*, 07 (05), 1999, p. 377-415.

At larger doses, the effects of amphetamine-type stimulants include:

- hallucinations;
- hyper-excitability;
- irritability;
- sense of power and superiority;
- panic; and
- paranoid psychosis.

Long-term effects of amphetamine-type stimulants are similar to those associated with cocaine use and vary with the mode of intake. They include:

- destruction of tissues in the nose;
- respiratorv problems;
- infectious diseases;
- abscesses;
- malnutrition;
- disorientation;
- apathy;
- confused exhaustion;
- development of tolerance and strong psychological dependence;
- paranoid psychosis; and
- depression.

(d) Ecstasy

Ecstasy and amphetamine-type stimulants are closely related in their chemical structure. However, the predominant pharmacological effect of ecstasy is somewhat different from amphetamines as ecstasy also has hallucinogenic effects. Ecstasy is produced through chemical synthesis in illicit laboratories. It is usually ingested, sometimes snorted, but rarely injected.

Sought-after effects of ecstasy include:

- enhanced communication skills;
- increased sense of sociability and closeness to others; and
- increased physical and emotional energy.

Short-term effects of ecstasy include:

- restlessness;
- increased blood pressure and heart rate;
- sweating;
- nausea and vomiting;
- grinding of the teeth;
- anxiety, fatigue and sometimes depression after use is stopped; and
- pronounced hallucinations at higher doses.

Long-term effects of prolonged regular use of ecstasy include the same effects as with other synthetic stimulants and may also cause permanent chemical changes in the brain as well as liver damage.

In the late 1990s, the proportion of the population aged 15 and above using amphetamines was estimated at 0.8% in North America and 0.5% in Europe, representing respectively 2.6 million and 3.3 million people. It has been estimated that some 33 million people, or 0.8% of the global population, abused amphetamines. On average, amphetamines account for some 10% of treatment demand worldwide.[45] Where ecstasy is concerned, it was estimated that 0.2% of the global population (7 million people) used this substance in the late 1990s. Western Europe and North America together account for almost 85% of global consumption.[46] In Europe, the annual prevalence of abuse as a percentage of the population aged 15 and above was highest in Ireland and in the United Kingdom with 2.4% and 1.6% of their respective population abusing ecstasy in the late 1990s. In Canada, the annual prevalence of abuse was 1.5% of the population aged 15 and above in 2000.[47] Among high school students (8th, 10th and 12th graders) in the United States, the annual prevalence rate of ecstasy use has increased significantly since 1996 from 3.8% to 6.3% in 2001. In Ontario, the annual prevalence rate of ecstasy use among high school students (age 13 to 18) also increased from 0.6% in 1993 to 6% in 2001.[48]

(e) Hallucinogens

The term hallucinogen from the Latin word "allucinari" meaning "to dream, to wander in the mind," is used to describe any substance that may produce distortions of reality and hallucinations. LSD, PCP, mescaline and psilocybin (magic mushrooms) are hallucinogens. Depending on the hallucinogen, the substance may be smoked, orally ingested, sniffed or snorted.

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[45] United Nations Office for Drug Control and Crime Prevention, *Global Illicit Drug Trends 2002*, New York, 2002, p. 260.

[46] Ibid., p. 265.

[47] Ibid., p. 267-68.

[48] Ibid., p. 269-70.

Sought-after effects of hallucinogens include:

- alterations in thought, mood and sensory perception;
- mind expansion;
- out-of-body experiences;
- empathy;
- enhanced communication skills; and
- increased sociability.

Short-term effects of hallucinogens are:

- distorted perception of depth and time, size and shape of objects;
- distorted perception of movements of stationary objects;
- intensified sensory perception; and
- increased risk of injuries related to such distortions of reality.

Unpleasant reactions of hallucinogens may include:

- anxiety;
- depression;
- dizziness;
- disorientation; and
- paranoia.

Physical effects of hallucinogens may include:

- nausea and vomiting;
- profuse sweating;
- rapid heart rate; and
- convulsions (rare).

"Flashbacks" of a previous hallucinogenic experience without using the substance again may occur days, weeks or even months after taking the last dose leading to disorientation, anxiety and distress. Some chronic users of hallucinogens may experience symptoms of psychological dependence — symptoms of physical dependence have not been observed.

Very little data is available on the use of hallucinogens at a global level. In Canada, the 1994 Alcohol and Other Drugs Survey did not include specific questions related to hallucinogens. The use of "LSD, speed or heroin" was reported by only 1% of respondents. However, student surveys reveal a much higher use of hallucinogens among youth. For example, according to the Ontario Student Drug Use Survey, 11.4% of students (Grade 7-OAC) reported past year use of hallucinogens in 2001.[49] A similar drug use survey of high school students in Quebec revealed 15.6% of students reported past year use of hallucinogens in 2000.[50]

(f) Cannabis

> *Dealing with cannabis itself, and simple possession of cannabis in particular, 21,000 people were charged with simple possession of cannabis in 1999. That's 11% more than in 1995. If you look across Canada, you'll see that charging patterns vary significantly from police force to police force, from a low of 25 per 100,000 for cannabis possession in Vancouver in 1998, to a high of 210 per 100,000 in Thunder Bay.*[51]

Cannabis refers to the flowering or fruiting tops of the cannabis plant, *Cannabis sativa* (Latin for cultivated hemp). The term cannabis is commonly used as a generic name for a variety of preparations obtained from the cannabis plant, which include commonly known substances such as marijuana, hashish and hash oil. Delta-9-tetrahydrocannabinol (THC) is the major psychoactive ingredient in cannabis products. Cannabis acts upon specific receptors in the brain. Cannabis products are usually smoked or orally ingested (food or tea).

Recent research and anecdotal evidence point to potential therapeutic uses of cannabis including managing pain, relieving nausea and vomiting caused by cancer chemotherapy, stimulating appetite and relieving the AIDS wasting syndrome, alleviating intraocular pressure associated with glaucoma, decreasing muscle spasms associated with generalized epilepsy and relieving spasticity arising from multiple sclerosis. Health Canada's Office of Cannabis Medical Access provides direct funding to support clinical trials into the safety and effectiveness of smoked and non-smoked marijuana and cannabinoids for medical purposes. The five-year research plan established in 2001 will provide a better understanding of the therapeutic uses of cannabinoids.

Sought-after effects of cannabis include:

- a sense of well-being, euphoria, relaxation; and
- enhanced sensory experiences.

Short-term effects of cannabis include:

- increased appetite;
- increased pulse rate;

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[49] Centre for Addiction and Mental Health, *Drug Use Among Ontario Students 1977-2001*, 2001, available online at www.camh.net/research/pdfs/osdus2001_DrugReport.pdf.

[50] Institut de la statistique du Québec, *L'alcool, les drogues, le jeu : les jeunes sont-ils preneurs? Enquête québécoise sur le tabagisme chez les élèves du secondaire (2000)*, vol. 2, 2002, available online at www.stat.gouv.qc.ca/publications/sante/pdf/RapAlcool_a.pdf.

[51] Croft Michaelson, Director and Senior General Counsel, Strategic Prosecution Policy Section, Department of Justice, Testimony before the Committee, October 1, 2001.

- cognitive and psychomotor impairment;
- talkativeness;
- perceptual alterations (colours and sounds are sharpened); and
- time distortion.

At very high doses, the effects of cannabis can be similar to those of hallucinogens. Regular heavy use of cannabis may lead to tolerance and heavy, long-term use, can cause dependence.

Long-term effects of cannabis include:

- a loss of drive and interest in sustained activity; and
- a risk of lung cancer, chronic bronchitis and other lung diseases if cannabis is smoked.

Cannabis is the most widely used illicit substance in the world, with 3.5% of the world's population reporting use in the late 1990s. Treatment demand for cannabis is significantly lower than for opiates or cocaine, but far from negligible. On average 15% of all treatment demand at the global level is attributed to problem use of cannabis and this percentage is on the increase as levels of consumption increase and as cannabis with higher THC levels becomes more available. In the late 1990s, the prevalence of cannabis use in the general population was 6.6% in North America and 4.9% in Europe, representing respectively 20.4 million and 31.1 million people.[52]

3. COMMITTEE OBSERVATIONS — USE AND HARMFUL USE OF SUBSTANCES

The Committee observed the following:

- √ *In Canada, there is an alarming lack of information on the prevalence of use and harmful use of substances, trends and overdoses, which impedes the development of sound drug policymaking.*
- √ *The harmful use of substances and dependence are chronic relapsing diseases requiring public health strategies. Our approach must be health-based and embrace all substances in use now and be prepared to deal with substances still to be developed.*
- √ *The harmful use of substances is not limited to the use of illicit substances. Harmful use of tobacco, alcohol, inhalants, prescription drugs and over-the-counter drugs is also prevalent and a serious concern to this Committee and many Canadians.*

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[52] United Nations Office for Drug Control and Crime Prevention, *Global Illicit Drug Trends 2002*, New York, 2002, p. 254.

- √ *While there are differing substance use patterns across communities in Canada, the harmful use of substances causes huge social, economic and health costs and has a devastating impact on individuals, families and neighbourhoods.*

- √ *There are alarming trends in use of substances: onset of use at a younger age; new synthetic drugs regularly coming on the market; and increased prevalence of use of substances by young people.*

- √ *The licit or illicit status of substances has little impact on their use.*

- √ *It is astounding that cannabis offences accounted for approximately three-quarters of all drug-related offences in 2001.*

- √ *The social and human tragedy associated with the harmful use of substances and the links to prostitution and exploitation of vulnerable groups were among the most compelling things that this Committee observed.*

- √ *There is a disturbingly high incidence of mortality and morbidity among injection drug users.*

- √ *Canadians must work hard to avoid the social havoc and costs associated with the use and harmful use of substances in other countries. Proactive measures invested in now will reap rewards in the future.*

- √ *We cannot ignore the impact of the pervasive use of substances on Canadian society. This is not someone else's problem. All orders of government and the private sector must work harder to reduce the use of substances and ensure Canadians enjoy healthy, safe lives.*

CHAPTER 3: CANADA'S DRUG STRATEGY

> *... Canada's drug strategy sunsetted in 1997. In my opinion, there has been a leadership vacuum on non-medical drug use since that time. While the federal government has not entirely disengaged itself from the issue, it removed an overarching and comprehensive national framework that had brought together partners from different jurisdictions to address pressing social, health, and economic impacts of substance abuse. On the federal scene today there is no visible government champion for non-medical drug use. This is a shame, because leadership in addiction research and policy requires a coordinated strategy involving multiple sectors, including the health, enforcement, judicial, and research sectors.*[53]

> *It is most important to recognize that you don't need to be compassionate to put dollars into substance abuse and addictions. You just have to think about the prosperity of your country. The social costs of untreated addictions are much greater than the social costs of most other health issues that mostly affect the individual. Addiction, because of the nature of what it is, not only affects the individual, but affects our neighbourhoods, our schools and every fabric of our society. It is just too costly in the bottom line to let this health issue get out of hand.*[54]

This chapter will provide an historical overview of Canada's Drug Strategy dating back to its origin in 1987. The information on the first two phases of the Drug Strategy covering the period 1987-1997 has been gathered from documentation. The Committee has concentrated its efforts on the study and evaluation of the current phase of Canada's Drug Strategy, phase three covering the period 1997-2002.

1. HISTORICAL OVERVIEW OF CANADA'S DRUG STRATEGY

(a) Phase I: 1987-1992

On May 25, 1987, Canada launched a five-year drug strategy[55] to address substance abuse-related concerns raised in 1986 by then Prime Minister Brian Mulroney who had declared that drug abuse had become an epidemic that undermined the economic and social fabric in Canada.[56] The Government of Canada allocated additional funds amounting to $210 million to support the new strategy, of which approximately 77% was to be directed to demand reduction measures such as education, prevention, treatment and rehabilitation. The emphasis on demand reduction was meant to achieve a more balanced approach as, at the time, much work was being done at the provincial, territorial and community levels to address demand reduction. The federal efforts were almost totally dedicated to supply reduction through enforcement, interdiction and control activities.[57]

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[53] Cameron Wild, Centre for Health Promotion Studies, University of Alberta, Testimony before the Committee, May 21, 2002.

[54] Patrick Smith, Executive Vice-President, Canadian Executive Council on Addictions, Testimony before the Committee, August 29, 2002.

[55] The strategy was entitled *National Drug Strategy: Action on Drug Abuse.*

[56] P. Erickson, "Recent Trends in Canadian Drug Policy: The Decline and Resurgence of Prohibitionism," *Daedalus*, 121.3, 1992, p. 248.

The National Drug Strategy (NDS) called for simultaneous and concerted action on six fronts: education and prevention, enforcement and control, treatment and rehabilitation, information and research, national focus, and international co-operation.[58] Acknowledging that substance abuse was primarily a health issue, the government designated the Health Minister as the lead minister for the NDS.

The first phase of the National Drug Strategy saw the implementation of a unique monitoring agency, the Canadian Centre on Substance Abuse (CCSA). Outside of Health Canada, the CCSA is the lead national agency on substance abuse in Canada. Following a proposal by the Task Force on the National Focus[59], and as part of the government's response to a report of the Standing Committee on National Health and Welfare, "Booze, Pills and Dope: Reducing Substance Abuse in Canada" (1987), an Act of Parliament created the Centre in 1988. The CCSA was to play a strong complementary role to that of the federal government as an independent national non-governmental organization mandated to provide a national focus for efforts to reduce health, social, and economic harm associated with substance abuse and addictions. The CCSA was placed within the portfolio of the Minister of Health, where it remains today. Specifically, the *Canadian Centre on Substance Abuse Act*[60] sets out five areas of responsibility for the CCSA:

- Promoting and supporting consultation and co-operation among governments, the business community and labour, professional and voluntary organizations in matters relating to alcohol and drug abuse;

- Contributing to the effective exchange of information on alcohol and drug abuse;

- Facilitating and contributing to the development and application of knowledge and expertise in the alcohol and drug abuse field;

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[57] Government of Canada, *Canada's Drug Strategy Phase II. A Situation Paper Rising to the Challenge*, Minister of National Health and Welfare, 1994, p. 6.

[58] Government of Canada, *National Drug Strategy: Action on Drug Abuse*, 1988.

[59] "In October 1987 the Minister of National Health and Welfare established a Task Force to examine how the special programs of excellence and the accumulated experience of federal, provincial and non-governmental organizations relevant to Canada's national and international concerns for alcohol and drugs could be used for the benefit of all Canadians." The Task Force on the National Focus, under the direction of Mr. David Archibald, President of the International Council on Alcohol and Addictions and founder of the Addiction Research Foundation, published their report on February 16, 1988.

[60] R.S., 1985, c. 49 (4th Supplement), available online at laws.justice.gc.ca.

- Promoting and assisting in the development of realistic and effective policies and programs aimed at reducing the harm associated with alcohol and drug abuse; and

- Promoting increased awareness among Canadians on the nature and extent of international efforts to reduce alcohol and drug abuse and supporting Canada's participation in those efforts.

(b) Phase II: 1992-1997

In March 1992, Cabinet renewed its commitment and launched a second phase of the strategy, entitled *Canada's Drug Strategy* (CDS), which regrouped the *National Strategy to Reduce Impaired Driving* and the *National Drug Strategy* under one initiative. Phase II was to focus on:

- Enhancing coordination at national, provincial, territorial and community levels;

- Improving the knowledge base for making program and policy decisions;

- Targeting resources to populations at high risk for substance abuse (out-of-the-mainstream youth, Aboriginal peoples, women, seniors and DWI offenders[61]); and

- The provision of supplemental resources for federal substance abuse programs and activities.[62]

In terms of enforcement, more attention was to be paid to implementing the Proceeds of Crime legislation. This minor shift in focus in Phase II of the strategy meant that 60%, rather than 70%, of resources would be allocated to demand reduction and 40% to supply reduction. Total funding for this second phase was set at $270 million over five years and it was accompanied by a requirement for the evaluation of the strategy. However, Health Canada estimated that only approximately $104.4 million was spent over five years on Phase II of Canada's Drug Strategy as a result of financial cuts in the overall funding of federal departments.[63] Phase II was to be coordinated by a newly created secretariat (1991), *Canada's Drug Strategy Secretariat*, to be housed in Health Canada.

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[61] DWI refers to driving while intoxicated.

[62] Health Canada, *Evaluation of Canada's Drug Strategy — Final Report*, June 1997, p. 1.

[63] Between 1995 and 1997, the federal government implemented its Program Review commitments as set out in the 1995 budget, which resulted in severe cutbacks in funding (a total of $9.8 billion) for most federal departments.

(c) Phase III: 1997-2002

In 1998, the Government of Canada reaffirmed the principles of a national drug strategy, however the funding was significantly reduced again. A 1998 document, entitled *Canada's Drug Strategy* (CDS), articulates the basic principles, goals, objectives and components of the strategy, as well as the directions and priorities of the federal government to address issues related to the use and abuse of substances such as alcohol, licit and illicit drugs. A committee comprised of representatives from 11 federal departments and a number of non-federal partners developed Canada's Drug Strategy.

The overarching principle of Canada's Drug Strategy is that substance abuse is primarily a health issue. This important principle raises awareness to the fact that the determinants of health and underlying factors such as housing, employment, social isolation and education, must be considered when addressing substance abuse problems. According to the director general of the Drug Strategy and Controlled Substances Programme who appeared before the Committee, Canada's Drug Strategy's approach to substance abuse involves action based on four pillars: control and enforcement, prevention, treatment and rehabilitation, and harm reduction.[64] The long-term goal of Canada's Drug Strategy is "to reduce the harm associated with alcohol and other drugs to individuals, families, and communities."[65] Reducing the harm associated with alcohol and other drugs is to be accomplished through five goals and corresponding objectives:

- **Reduce the demand for drugs**
  - ➢ Increase the understanding of risks associated with illicit drug use (particularly among youth), with particular emphasis on the use of "hard drugs" such as cocaine, LSD, speed and heroin.
- **Reduce drug-related mortality and morbidity**
  - ➢ Reduce high-risk patterns of alcohol and other drug use, including the inappropriate use of inhalants, medications, and performance-enhancing sport drugs.
- **Improve the effectiveness of and accessibility to substance abuse information and interventions**
  - ➢ Identify and promote best practices in substance-abuse prevention, education, treatment and rehabilitation.

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[64] Dr. Jody Gomber, Director General, Drug Strategy and Controlled Substances Programme, Healthy Environments and Consumer Safety Branch, Health Canada, Testimony before the Committee, October 3, 2001.

[65] Government of Canada, *Canada's Drug Strategy*, Health Canada, 1998, p. 4.

- **Restrict the supply of illicit drugs and reduce the profitability of illicit drug trafficking**
    - Reduce the illegal importation of illicit drugs.
    - Reduce the reported availability of illicit drugs at the street level.
    - Reduce the ability of persons involved in the supply and trafficking of drugs to make use of the profits of their illegal actions.
- **Reduce the costs of substance abuse to Canadian society**[66]

To achieve these goals and objectives, seven components have been selected to provide the framework for Canada's Drug Strategy:

- Research and knowledge development;
- Knowledge dissemination;
- Prevention programming;
- Treatment and rehabilitation;
- Legislation, enforcement and control;
- National co-ordination; and
- International co-operation.

Health Canada is the lead department on Canada's Drug Strategy. To coordinate the Strategy, Health Canada chairs the Assistant Deputy Ministers' Steering Committee on Substance Abuse and interdepartmental committees such as the Interdepartmental Working Group on Substance Abuse. Coordination is key to the success of a federal drug strategy as numerous partners including 14 federal departments, provincial and territorial governments, law enforcement and addictions agencies, and non-governmental organizations are collaborating on Canada's Drug Strategy. The Web site of Health Canada lists the following federal departments: Solicitor General, Foreign Affairs and International Trade, Finance, Canadian Heritage, Justice, Canada Customs and Revenue Agency, Transport, Human Resources Development, Status of Women, Indian and Northern Affairs, Canada Mortgage and Housing Corporation, Treasury Board, and Privy Council Office. However, only a few of these departments administer programs focused specifically on substance use related problems.

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[66] The goals and objectives are taken verbatim from Government of Canada, *Canada's Drug Strategy*, Health Canada, 1998, p. 4-5.

The Healthy Environments and Consumer Safety Branch (HECSB), within Health Canada, is home to the Office of Canada's Drug Strategy, the Office of Controlled Substances, the Office of Cannabis Medical Access, and the Drug Analysis Service which together share responsibility for the Drug Strategy and Controlled Substances Programme. HECSB is also home to the national strategy on tobacco control.

The Office of Canada's Drug Strategy[67] (OCDS) is responsible for:

- Collaborating with other departments, governments and expert bodies by chairing federal/provincial/territorial committees, advisory committees and interdepartmental meetings;
- Researching, analyzing and distributing leading-edge information about substance abuse, including best practices for prevention, treatment and rehabilitation;
- Working multilaterally with groups, such as the United Nations Drug Control Programme, and with other countries to address the global drug problem; and
- Managing the Alcohol and Drug Treatment and Rehabilitation Program, a cost-share contribution program involving the provinces and territories.

The Office of Controlled Substances works to ensure that drugs and controlled substances are not diverted for illicit use. The Office of Cannabis Medical Access co-ordinates the development of, and administers, the *Marihuana Medical Access Regulations*. The Drug Analysis Service provides expert advice and analytical support to law enforcement agencies by analyzing the content of substances and determining the quantity of illicit drugs seized by such agencies, as well as assisting in the investigation and dismantling of clandestine laboratories.[68]

There are several other branches within Health Canada that are involved in some form or other with the use and harmful use of substances. The Population and Public Health Branch of Health Canada is concerned with numerous public health issues related in some way to substance use, such as HIV/AIDS, Hepatitis C, mental health, Fetal Alcohol Syndrome/Fetal Alcohol Effects (FAS/FAE)[69], medication and alcohol use by seniors, family violence prevention, and the safety and healthy development of children and youth.

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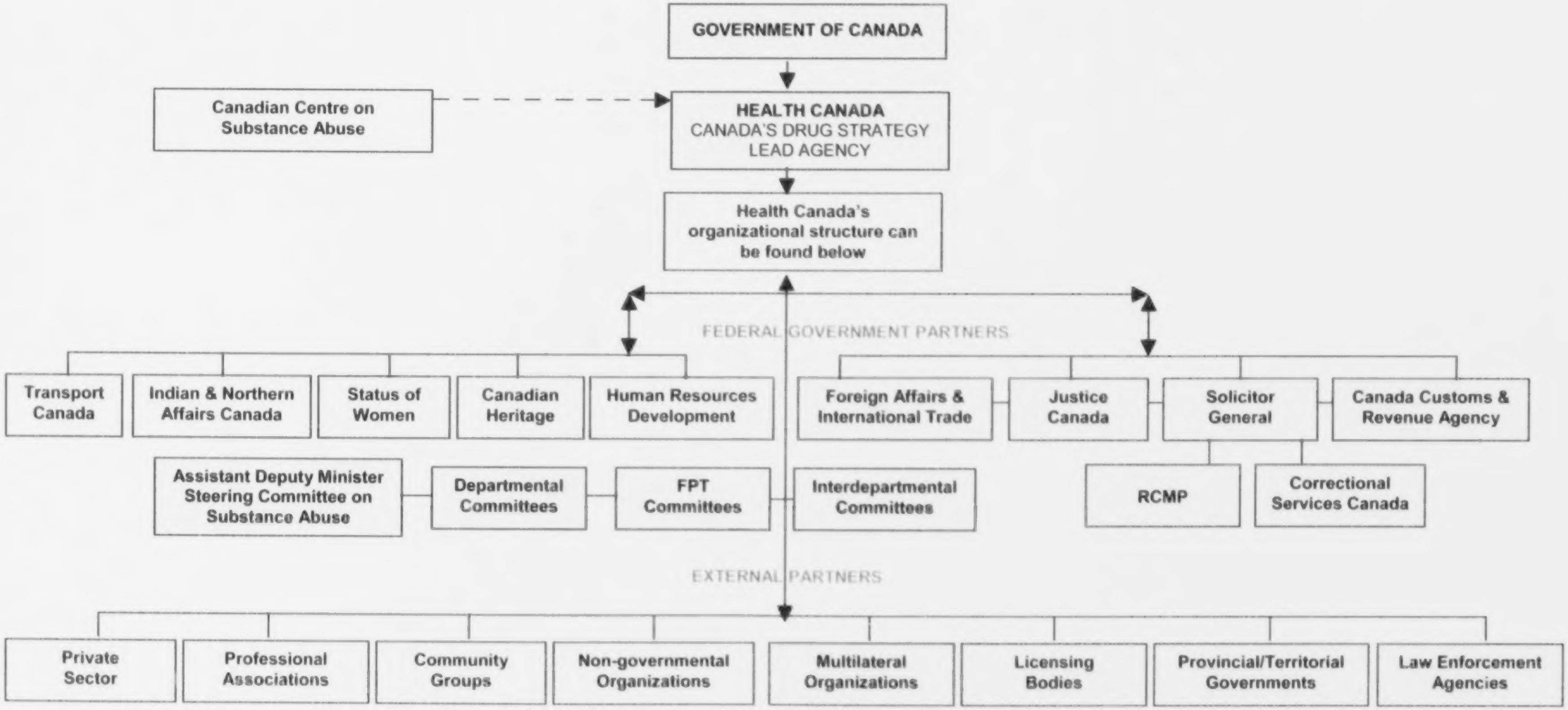
[67] The information on the offices managing the Drug Strategy and Controlled Substances Programme was taken from the Programme's Web site at www.hc-sc.gc.ca/hecs-sesc/hecs/dscs.htm.

[68] Ibid.

[69] Fetal Alcohol Syndrome/Fetal Alcohol Effects (FAS/FAE) are terms used to describe a medical diagnosis or a possible cause of a disability associated with the use of alcohol during pregnancy, often resulting in life-long disabilities.

CURRENT ORGANIZATIONAL STRUCTURE

CANADA'S DRUG STRATEGY



GOVERNMENT OF CANADA

Canadian Centre on Substance Abuse

HEALTH CANADA
CANADA'S DRUG STRATEGY LEAD AGENCY

Health Canada's organizational structure can be found below

FEDERAL GOVERNMENT PARTNERS

Transport Canada

Indian & Northern Affairs Canada

Status of Women

Canadian Heritage

Human Resources Development

Foreign Affairs & International Trade

Justice Canada

Solicitor General

Canada Customs & Revenue Agency

Assistant Deputy Minister Steering Committee on Substance Abuse

Departmental Committees

FPT Committees

Interdepartmental Committees

RCMP

Correctional Services Canada

EXTERNAL PARTNERS

Private Sector

Professional Associations

Community Groups

Non-governmental Organizations

Multilateral Organizations

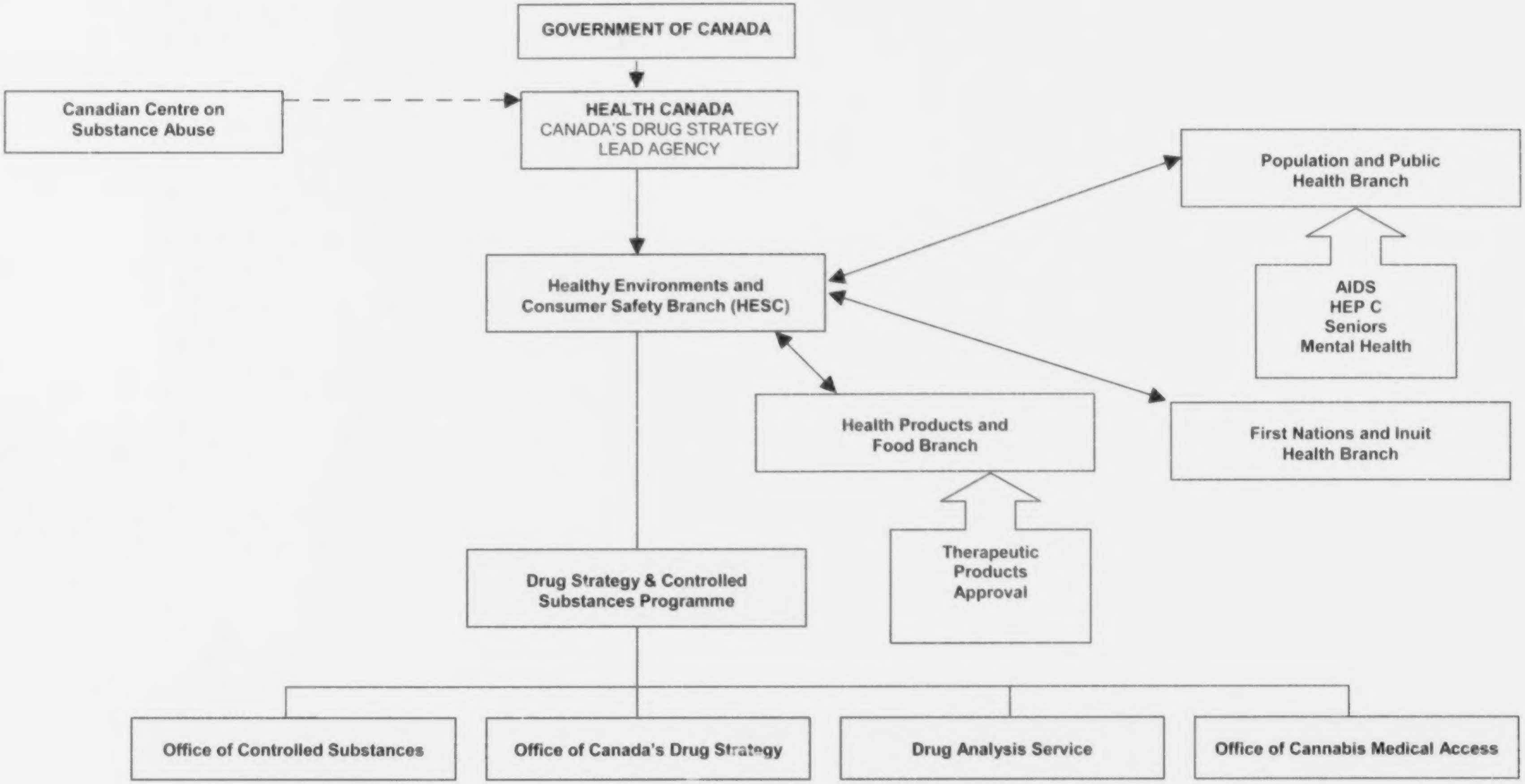
Licensing Bodies

Provincial/Territorial Governments

Law Enforcement Agencies

CURRENT ORGANIZATIONAL STRUCTURE

CANADA'S DRUG STRATEGY – HEALTH CANADA



GOVERNMENT OF CANADA

Canadian Centre on Substance Abuse

HEALTH CANADA
CANADA'S DRUG STRATEGY
LEAD AGENCY

Healthy Environments and Consumer Safety Branch (HESC)

Population and Public Health Branch

AIDS
HEP C
Seniors
Mental Health

Health Products and Food Branch

Therapeutic Products Approval

First Nations and Inuit Health Branch

Drug Strategy & Controlled Substances Programme

Office of Controlled Substances

Office of Canada's Drug Strategy

Drug Analysis Service

Office of Cannabis Medical Access

As the federal government is the primary provider of health care to First Nations people and Inuit, the First Nations and Inuit Health Branch of Health Canada funds treatment services for on-reserve First Nations people and Inuit through the National Native Alcohol and Drug Abuse Program (NNADAP).

Health Canada reports the following current expenditures on the Drug Strategy and Controlled Substances Programme.[70]

HEALTHY ENVIRONMENTS AND CONSUMER SAFETY BRANCH
Drug Strategy and Controlled Substances Programme:

Administration of regulations except MMAR[71]	$ 5	M
Medical Marihuana Programme	$ 5	M
Drug analytical services	$ 4.5	M
Policy, Research and International Affairs	$ 4	M
Alcohol and Drug Treatment and Rehabilitation[72]	$ 14	M
Canadian Centre on Substance Abuse	$ 1.5	M
Sub-total	**$ 34**	**M**
First Nations and Inuit Health Branch (Alcohol, Solvents)	$ 70	M
Total	**$104**	**M**

The expenditures above strictly reflect what Health Canada, the lead agency in charge of Canada's Drug Strategy, spends on the Drug Strategy and Controlled Substances Programme, the Canadian Centre on Substance Abuse and the programs offered through the First Nations and Inuit Health Branch. It is clearly apparent to the Committee that Health Canada's expenditures reflect severe financial cuts to Canada's Drug Strategy since its creation in 1987 that have yet to be restored. It is also the Committee's belief that the social and health costs associated with the harmful use of substances have not decreased during that period but have actually increased substantially.

According to the *2001 Report of the Auditor General of Canada*, 11 departments and agencies are currently actively involved in Canada's Drug Strategy and "spend approximately $500 million annually to address illicit drug use in Canada."[73] It is estimated that 95% of these expenditures are used for supply reduction (enforcement and interdiction) through the work done by the Royal Canadian Mounted Police (RCMP), Correctional Service Canada and the Department of Justice.[74] However, the strategy is supposed to reflect a balance between reducing the supply of, and the demand for, drugs.[75] Many witnesses appearing before the Committee argued that the prime focus of Canada's Drug Strategy has been supply reduction activities to the detriment of demand reduction measures. Federal departments appearing before the Committee were unable to provide details concerning the allocation of Canada's Drug Strategy funding or to identify clearly the results of that investment. The Auditor General estimated the federal expenditures that address illicit drugs for 1999-2000 as follows:

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[70] Dann Michols, Assistant Deputy Minister, Healthy Environments and Consumer Safety Branch, Health Canada, Testimony before the Committee, August 28, 2002.

[71] Marihuana Medical Access Regulations.

[72] Health Canada provides $14 million to the provinces and territories through a cost-sharing initiative to increase and expand innovative and effective treatment and rehabilitation programs related to alcohol and other drugs.

[73] Office of the Auditor General of Canada, *2001 Report of the Auditor General of Canada*, Chapter 11 — Illicit Drugs: The Federal Government's Role, 2001, p. 2.

ESTIMATED FEDERAL EXPENDITURES THAT ADDRESS ILLICIT DRUGS FOR 1999-2000[76]

Department or agency	Activities	Estimated 1999-2000 expenditures ($ millions)		
		Supply reduction	Demand reduction	Total
Canadian Centre on Substance Abuse	Promotes drug awareness, harm reduction, effectiveness of programs, and development and exchange of information.	-	1	1
Canada Customs and Revenue Agency	Intercepts illicit drugs and drug traffickers at the Canadian border.[1]	14 to 36	-	-
	Administers Special Enforcement Program aimed at people profiting from illegal activities.[2]	(4)	-	10 to 32
Canadian Institutes of Health Research	Funds research projects on addiction.	-	1	1
Correctional Service Canada	Deals with offenders serving sentences in whole or part for drug-related offences.[3]	154	-	-
	Administers substance abuse programs, including alcohol.	-	8	-
	Administers treatment programs (for example, methadone).	-	4	-
	Conducts urinalysis testing.	3	-	-
	Undertakes security measures to control supply in institutions.	Unknown	-	169
Department of Foreign Affairs and International Trade	Manages Canada's international drug activities, including contributions to the United Nations Drug Control Program and the Inter-American Drug Abuse Control Commission.	1	1	2
Department of Justice	Prosecutes drug offences.	56	-	-
	Provides legal aid and contributions to provinces and territories for juvenile justice services ultimately used for drug cases.	14	-	-

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[74] Ibid., p. 15.

[75] Government of Canada, *Canada's Drug Strategy*, Health Canada, 1998, p. 1.

[76] Table reproduced from the *2001 Report of the Auditor General of Canada*, Chapter 11 — Illicit Drugs: The Federal Government's Role, Office of the Auditor General of Canada, 2001 p. 16-17.

	Carries out projects (by its National Crime Prevention Centre) focussed on alcohol and drug abuse.	-	1	71
Health Canada	Provides laboratory analysis services to the police to test suspected seized drugs.	5	-	-
	Administers controlled drug legislation, including import-export licence responsibilities.	2	-	-
	Makes contributions under the $15.5 million "Alcohol and Drug Treatment and Rehabilitation Program" (ADTR). Our estimate of the illicit drug portion is $7 million.	-	7	-
	Coordinates Canada's Drug Strategy and manages the ADTR program.	-	1	15
National Parole Board	Makes parole decisions on offenders sentenced for serious drug offences.	4	-	4
Public Works and Government Services Canada	Manages assets seized by law enforcement and distributes residual proceeds upon disposal.[4]	(10)	-	(10)
Royal Canadian Mounted Police (Federal Policing Services)	Focusses on large-scale trafficking and importation cases involving organized crime, seizure of assets from proceeds of crime, and intelligence and specialized services such as physical and electronic surveillance. Participates in joint force operations that are both ad hoc and permanent.	164	-	-
	Administers drug awareness programs.	-	4	168
Solicitor General Canada	Administers policy, conducts research, and coordinates enforcement activities.	1	-	1
	Total	**404 to 426**	**28**	**432 to 454**

[1] Because the Agency's illicit drug interdiction work is highly integrated with its other activities, the estimate is presented as a likely range within which the cost of drug interdiction falls. This represents between 4 and 8 percent of its 1999-2000 expenditures totalling $464 million.

[2] The figure shown is assessed taxes and fines net of investigation costs.

[3] This estimate covers all aspects associated with drug offenders incarcerated and under community supervision, including both direct and indirect costs.

[4] The figure shown is the federal government's share of revenue generated from the disposal of assets seized from the drug trade net of costs incurred by the Department to manage the assets. The total federal government's share of revenue net of costs was $10 million. RCMP investigation and Department of Justice prosecution costs, which total over $40 million annually, are not included in this figure.

2. NATIONAL DRUG STRATEGY: ACHIEVEMENTS AND SHORTCOMINGS OF PHASE I (1987-1992)

Phase I of the National Drug Strategy (NDS) was not subject to a formal evaluation. Nonetheless, based on a review of official documents, some of the achievements of the NDS included:

- "Really Me!"/"Drogues pas besoin," a public awareness and information campaign was launched in June 1987. The campaign used a multi-media approach to reach young people and parents. The progress of the campaign was monitored by a series of tracking surveys, which concluded that it had achieved a high level of awareness within the target audience. "The target audiences were reached with appropriate, effective messages that they were able to identify with and to which they were receptive."[77]

- Alcohol and Drug Treatment and Rehabilitation Program (ADTRP), a cost-shared initiative with federal contributions to the provinces for direct provincial alcohol and drug expenditures, was developed and implemented in the course of the first phase of the strategy (1988-1989). Federal funding was set at a maximum of $20 million per year and federal contributions were to be matched by the provinces on a 50-50 basis.[78] The ADTRP initiative is ongoing.

- A National Research Agenda of $6.6 million "designed to foster and support research into the factors which contribute to alcohol and drug abuse, and the evaluation of innovative programs aimed at the prevention and treatment of abuse"[79] was developed early into Phase I of the strategy. As of March 31, 1992 the initiative had invested more than $4.6 million in research on alcohol and drug abuse.[80] A first national survey on the use of alcohol and other drugs was completed in 1989.

- The Canadian Centre on Substance Abuse was created in 1988.

- The Office of the National Strategy for Drug Prosecutions within Justice Canada was established during the first phase of the strategy.

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[77] Health Canada, *Really Me!*, Social Marketing Network, available online at www.hc-sc.gc.ca/hppb/socialmarketing/case_reallyme.html.

[78] Government of Canada, *National Drug Strategy: Action on Drug Abuse*, 1988.

[79] Ibid.

[80] Government of Canada, *Canada's Drug Strategy Phase II. A Situation Paper Rising to the Challenge*, Minister of National Health and Welfare, 1994, p. 33.

- Drug interdiction was strengthened through the expansion of Canada Customs drug teams, Canada Customs Detector Dog Service, Crime Stoppers, and through enhanced training for customs inspectors as well as enhanced co-operation with the transportation industry.[81]

Virtually no information was brought to the Committee's attention with respect to shortcomings in the first phase of Canada's Drug Strategy. However, based on a review of documentation, a lack of coordination at the interdepartmental level appears to have been the main weakness of Phase I of the Drug Strategy.

3. CANADA'S DRUG STRATEGY: ACHIEVEMENTS AND SHORTCOMINGS OF PHASE II (1992-1997)

Phase II of Canada' s Drug Strategy (CDS) was subject to an evaluation, the final report of which was published in June 1997. Phase II saw a renewed emphasis on research with a national focus. For example, funds were used to conduct a second national survey on the use of alcohol and other drugs in 1994. The Canadian Centre on Substance Abuse, in collaboration with the Addictions Research Foundation, published *Canadian Profile 1994*, an analysis of the national survey. The first comprehensive study of the health, social and economic costs associated with the use of alcohol, tobacco and illicit drugs was also published by the Canadian Centre on Substance Abuse in 1996. Nonetheless, Phase II had important shortcomings as well and once again interdepartmental coordination was a major concern. For example, clear coordination goals were not set for Canada's Drug Strategy Secretariat, which resulted in a disagreement among federal departments as to the role the Secretariat should play in relation to departments outside of Health Canada. Situated within Health Canada, the Secretariat was moved several times within the department's organizational structure before finally being disbanded in the spring of 1996.[82]

The final evaluation report concluded that:

- The information available in Canada on the issue of substance abuse increased as a result of CDS Phase II funding.[83]

- CDS Phase II dollars enabled many new and enhanced activities to take place, however the timing of activities and cuts to funding levels may have limited the degree of impact achieved on actual programming.[84]

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[81] Government of Canada, *National Drug Strategy: Action on Drug Abuse*, 1988.

[82] Health Canada, *Evaluation of Canada's Drug Strategy — Final Report*, June 1997, p. 10 and p. 35.

[83] Ibid., p. 13.

[84] Ibid., p. 36.

- Health Canada forged new partnerships and developed innovative program development methods and strategies designed to meet the needs of high risk and hard-to-reach populations.[85]

- The CDS Phase II did not have national visibility at either political or public levels.[86]

- The lack of interdepartmental coordination and strategic planning remained a weakness throughout the life of CDS Phase II.[87]

- Health Canada did not monitor expenditures on CDS Phase II in a consistent and complete manner.[88]

- To be successful, the implementation of a federal drug strategy would require: further changes to the federal government-wide organizational culture, effective management structures and processes which can maximize the benefits of working horizontally, and an on-going focus on accountability.[89]

4. CANADA'S DRUG STRATEGY: ACHIEVEMENTS AND SHORTCOMINGS OF PHASE III (1997-2002)

Health Canada's evaluation of CDS Phase II revealed a number of key components that had to be implemented if Canada's Drug Strategy was to be successful in the future. Were the lessons learned in Phase II taken into consideration and put into practice in Phase III? What has been achieved under Canada's Drug Strategy since 1997?

The Committee had difficulty getting answers to these questions from Health Canada and other departments involved in the implementation of Canada's Drug Strategy. The Committee received only anecdotal evidence and the testimony of a very small number of witnesses suggesting there had been a lot of good work done under the rubric of Canada's Drug Strategy and that money had been well spent.[90] The Committee is seriously concerned with the apparent lack of information on the achievements and shortcomings of the federal drug strategy. Those concerns were echoed in the testimony of the Deputy Auditor General:

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[85] Ibid., p. 36.

[86] Ibid., p. 13.

[87] Ibid., p. 25.

[88] Ibid., p. 36.

[89] Ibid., p. 25.

[90] Dann Michols, Assistant Deputy Minister, Healthy Environments and Consumer Safety Branch, Testimony before the Committee, August 28, 2002.

> *Departmental performance reports lack information on results. ... The real weakness, however, is the lack of a comprehensive public report that tells parliamentarians and Canadians how well Canada — either federally or nationally — is managing the problem. Canada's Drug Strategy needs clear, measurable objectives so that overall performance can be reported.*[91]

Representatives of the Drug Strategy and Controlled Substances Programme (DSCSP) appeared before the Committee on two different occasions to respond to these concerns. Early into the Committee's study, Dr. Jody Gomber, who at the time was the Director General of the DSCSP, stated that a lack of financial resources explains why no evaluation of Canada's Drug Strategy has been undertaken since 1997.

> *But I think the question of how we measure our activities is a good one, and a very difficult one. Canada's drug strategy phase one — and that was 1987-92 — had some specific goals and targets and a specific amount of funding associated with it. Likewise, the second phase had specific goals and targets and funding associated with it. When the funding for those projects ran out, Canada's Drug Strategy, the document, was published, but unfortunately, there was not a great deal of funding available to do things like evaluate the effectiveness of the activities that had gone on. So I agree with you that it's important to evaluate those things, but unfortunately, there has not been much opportunity to do that.*[92]

Near the conclusion of the Committee's study, Mr. Dann Michols, Assistant Deputy Minister, Healthy Environments and Consumer Safety Branch, further explained how Health Canada, notwithstanding the fact that it is CDS lead agency, does not have the authority to evaluate how other federal departments are spending their dollars or how they are fulfilling their mandate under Canada's Drug Strategy.

> *Health Canada is responsible for the coordination of the drug strategy. We cannot go into a department. We cannot analyze its books. We cannot pull out the information. We coordinate a team, if you like, that has to come together, realizing that the goal is important, and has the resources to do it. It may be a function not of the fact that they don't want to supply that information, but that they may just not have the wherewithal by which to collect it, analyze it, and disseminate it.*[93]

The Committee recognizes that budget cuts have adversely affected the monitoring of Canada's Drug Strategy. Unfortunately, in a context of fiscal constraint, delivering programs takes priority over any long-term evaluation expenditures. However, testimony before the Committee suggests that the Government of Canada and Parliament's failure to make the harmful use of substances a priority would also explain why this issue has been so neglected in recent years.

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[91] Michael McLaughlin, Opening Statement of Michael McLaughlin before the Committee, February 6, 2002.

[92] Dr. Jody Gomber, Testimony before the Committee, October 3, 2001.

[93] Dann Michols, Assistant Deputy Minister, Healthy Environments and Consumer Safety Branch, Department of Health, Testimony before the Committee, August 28, 2002.

Many witnesses appearing before the Committee, as well as the *2001 Report of the Auditor General of Canada*, raised concerns about the federal government's efforts to address the use and harmful use of substances within the context of Canada's Drug Strategy. Some of the concerns expressed include:

- No clear commitment from the Government of Canada to making the harmful use of substances and its related consequences a federal priority;
- Unstable funding and lack of resources to effectively implement Canada's Drug Strategy;
- Lack of federal leadership and coordination of Canada's Drug Strategy;
- Lack of focus and ineffectiveness of current coordination mechanisms (i.e., Federal/Provincial/Territorial Committee on Alcohol and Other Drug Issues; Interdepartmental Working Group on Substance Abuse);
- No clear and measurable goals and no requirement to regularly evaluate the effectiveness of Canada's Drug Strategy;
- No mechanisms to ensure accountability and scrutiny of expenditures;
- Lack of balance between the efforts that address supply and demand reduction;
- Lack of communication and co-operation between all the partners involved in implementing Canada's Drug Strategy, including federal, provincial, territorial and municipal governments as well as non-governmental addiction agencies;
- Lack of up-to-date data on the prevalence of use and harmful use of substances in Canada;
- Lack of knowledge on the programs and measures currently in place to address all components of the drug strategy (prevention and education, treatment and rehabilitation, harm reduction, and enforcement and control); and
- No comprehensive public reporting mechanism on the implementation of Canada's Drug Strategy.

The Committee had the opportunity to travel to major cities across Canada and see first-hand the devastation caused by the harmful use of substances in the current policy and legal environment. It acknowledges all the above shortcomings of the latest phase of Canada's Drug Strategy. The Committee also recognizes that, as noted in the *2001 Report of the Auditor General*, "[m]anaging the illicit drug problem in Canada is inherently difficult. It requires the efforts of three levels of government — federal, provincial/territorial and municipal — and many non-government organizations."[94] Given Canada's constitutional division of powers, the implementation of a consistent federal drug strategy dealing with the harmful use of substances is indeed made more challenging and calls for all orders of government to work together.

The *Constitution Act, 1867* gives the provinces power to legislate in the fields of health care, education, provincial jails, and the administration of the courts; while giving Parliament power over criminal law and procedure, as well as the management of penitentiaries. Parliament exercises its authority to pass laws regulating the sale, distribution and possession of psychoactive substances through the *Controlled Drugs and Substances Act.* Responsibility for providing health care and, therefore, treatment and rehabilitation for substance dependence, falls primarily to the provinces.

Although the federal government contributes funds toward the provision of health care, including treatment for substance dependence, and Health Canada provides leadership in the formulation of a federal response to the problem of the harmful use of substances and dependence, there are constitutional constraints that limit the federal government's ability to act in certain spheres. For example, Health Canada may conduct public awareness campaigns, develop materials, and make suggestions for delivering education and prevention programs in schools. However, the provinces ultimately have the power to develop curricula that may or may not incorporate those suggestions. Similarly, while the federal government may encourage physicians and pharmacists to develop reporting systems that would allow for closer monitoring of prescription drugs so as to limit their misuse and their diversion into the illicit market, the regulation of those professions is under the control of the provinces.

In light of the constitutional context, the development of effective federal policies for dealing with the use and harmful use of substances, and dependence, will depend very much on the federal government's ability to demonstrate leadership and vision within its own jurisdiction and to effectively coordinate a renewed and well-funded Canadian drug strategy. However, as the provinces, territories and municipalities play a key role in dealing with the use and harmful use of substances, the success of Canada's Drug Strategy will also rest on the federal government's ability to elicit co-operation and to work in partnership with other orders of government.

> *I think the major role of the federal government ... since most of the costs are not borne by the federal government other than the specialized drug enforcement, most of the costs are borne by the provinces through health care services and ordinary police forces and law enforcement agencies. I think the best role the federal government can play is to provide national co-ordination and leadership and a research base to avoid the inefficiencies of people duplicating effort throughout the country, standardization of measures, things like that, and basically*

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[94] Office of the Auditor General, *2001 Report of the Auditor General of Canada*, Chapter 11 — Illicit Drugs: The Federal Government's Role, 2001, p. 14.

> *identify where the next things should go. A drug strategy should focus specifically on new and innovative programming. It should be the rudder that steers the ship. It's not the ship itself.*[95]

A grave concern expressed by the vast majority of witnesses and acknowledged by the Committee relates to the consequences of the cutbacks in funding on Canada's Drug Strategy. Many witnesses have argued that financial cuts have been so severe that the year 1997-1998 marks, in fact, the sunset of Canada's Drug Strategy:

> *This parliamentary Committee on the Non-Medical Use of Drugs has a very important mandate. Indeed, the field of addictions in Canada is looking to you to serve as a catalyst for action and leadership from the federal government. As I am sure others have stated, Canada does not have a national drug strategy. We are the only G8 country that does not have a national drug strategy.*[96]

In response to an inquiry from the Committee, Health Canada stated, "since 1997, the level of activity by the Office of Canada's Drug Strategy (OCDS) and its partners has been reduced. The office focuses predominantly on: legal obligations, international commitments, rehabilitation and critical issues such as injection drug use."[97] Cutbacks in funding may have further exacerbated the imbalance between demand and supply reduction, as measures targeting the demand for substances appear to have been more affected by the cuts in funding than enforcement measures aimed at reducing the supply of illicit substances.

The Canadian Centre on Substance Abuse (CCSA) was particularly affected by the cuts in funding. In 1988, the CCSA had received an initial annual grant from the federal government of $2 million as a minimum base of funding to set up the Centre and to leverage investments from other orders of government and non-governmental organizations. With the effective sunset of Canada's Drug Strategy in 1997, its budget was reduced by 75% to $500,000. The Centre has survived primarily through contract-based services. Mounting financial and human resource pressures continue to threaten the existence of the CCSA.[98] Nonetheless, the Centre has managed to deliver services and position itself both nationally and internationally as Canada's focal point for substance abuse matters. In 2002, Health Canada increased the Centre's funding to $1.5 million as an interim measure awaiting the implementation of a new federal drug strategy. The Committee acknowledges the sustained efforts of the Canadian Centre on Substance Abuse and believes its legislated mandate continues to be relevant and crucial to the future success of a renewed Canadian drug strategy. The CCSA will be discussed in more detail in Chapter 4, which deals specifically with research, information and knowledge management.

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[95] Eric Single, Testimony before the Committee, November 7, 2001.

[96] Murray Finnerty, Canadian Executive Council on Addictions, Testimony before the Committee, August 29, 2002.

[97] Health Canada, *Response to the Committee*, 2002, p. 17.

[98] The CCSA is an arm's-length organization and therefore incurs costs such as those related to operating a Board of Directors, conducting annual audits, legal and accounting services, rent and all other infrastructure expenditures associated with running such a centre.

5. WHERE DO WE GO FROM HERE?

In Canada, in the last decade, findings of concurrent harmful use of substances and mental health disorders have increased; the number of individuals dependent on substances who also suffer from Fetal Alcohol Syndrome and Fetal Alcohol Effects is more apparent; the number of injection drug users who are HIV positive, have AIDS or Hepatitis C has increased; poly-drug use is a growing trend; use of synthetic designer drugs is on the rise; and traditional views on the harmful use of substances, and dependence, are constantly being challenged by new research into the bio-psycho-social aspects of alcohol and substance use problems. The Committee believes that investing in a renewed Canadian drug strategy is critical and will contribute to reducing the demand for, and consequently, the supply of substances, as well as reducing the spread of infectious diseases and the social and health costs associated with the harmful use of substances.

The renewed Canada's Drug Strategy must be comprehensive, integrated, balanced and sustainable and include alcohol, tobacco, illicit substances and pharmaceutical drugs. The cornerstone of a renewed drug strategy must remain the long-term goal of reducing the harm associated with alcohol, tobacco and other substances to individuals, families and communities. The guiding principles, short-term goals, objectives, performance indicators and strategic plan should be determined by the Canadian Centre on Substance Abuse in consultation with representatives from Health Canada, concerned departments of all orders of government, non-governmental agencies dedicated to addictions, the private sector as well as drug/substance users. A shared decision-making process involving key stakeholders across the country will enhance co-operation and ensure a higher level of visibility for the renewed federal drug strategy. The Government of Canada should take immediate action to ensure that a well-funded federal drug strategy will be in place by summer 2003.

High priority should be given to the development of a strategy that would include:

- Prevention and education initiatives (wherever possible, in collaboration with provincial and territorial governments);
- Research, knowledge and evidence-based practices;
- A clear set of achievable goals and objectives and measurable outcomes;
- An evaluation framework;

- An accountability framework to identify roles and responsibilities as well as the mechanisms for tracking expenditures and achievements;
- Harm reduction measures;
- Multi-sectoral partnerships to leverage existing resources; and
- A federal/provincial/territorial government communication plan.

6. OVERSEEING CANADA'S DRUG STRATEGY

Given the need for fiscal and program accountability, and for ongoing evaluations of Canada's Drug Strategy, the Committee believes that there must be a change in structure and reporting mechanisms to better reflect Parliament's commitment to addressing the harmful use of substances in Canada. Because the relevant issues cut across many aspects of society, responsibility for implementing a federal drug strategy is shared by various federal departments and agencies. The Committee believes that shared responsibility in this instance has led to a diffusion of fiscal accountability. The resulting lack of comprehensive budget information was pointed out in the *2001 Report of the Auditor General*. For that reason, the Committee recommends the appointment of a Canadian Drug Commissioner, independent of any federal department or agency, to oversee Canada's Drug Strategy. The Canadian Drug Commissioner must be mandated to monitor, investigate and audit the implementation of the strategy, and to report and make recommendations annually to Parliament through the Speaker of the House of Commons.

An Act of Parliament should establish the Canadian Drug Commissioner's position and define his mandate, basic functions and powers, as well as the organizational structure of his office. The Committee suggests that the Governor in Council appoint the Canadian Drug Commissioner, preferably with a background in health issues, for a term not exceeding five years and that the budget for the office of the Canadian Drug Commissioner be set at $1.5 million per year.

The Canadian Drug Commissioner's role would be to assist parliamentarians in overseeing the implementation and progress of a renewed Canada's Drug Strategy by providing them with an objective, independent analysis as well as by making recommendations for further necessary action to ensure the success of Canada's Drug Strategy. To facilitate the work of the Canadian Drug Commissioner, federal departments and agencies would be required to prepare action plans outlining how they will implement Canada's Drug Strategy. The Commissioner would then monitor the extent to which departments and agencies implement these actions plans and meet the objectives of Canada's Drug Strategy.

Who should implement the new federal drug strategy? Many key stakeholders testified before the Committee that it is appropriate that Health Canada continue to take primary responsibility for the multi-departmental implementation of Canada's Drug Strategy, so as to reinforce the message that the harmful use of substances, and dependence, are primarily health issues. The Committee agrees but would like to see a higher priority placed on that portfolio, with an enhanced public profile and greater accountability. Consequently, the Committee believes that the Minister of Health should be mandated to respond to the Canadian Drug Commissioner's annual report in an annual statement to the Standing Committee on Health, through the House of Commons.

7. COMMITTEE OBSERVATIONS — CANADA'S DRUG STRATEGY

The Committee observed the following:

√ *A renewed well-funded federal drug strategy is desperately needed if we are to ensure the best possible health for Canadians and their communities.*

√ *A renewed Canada's Drug Strategy must include clear and measurable goals and objectives, and require comprehensive evaluations to ensure that these goals and objectives are being met.*

√ *The primary focus of Canada's Drug Strategy in recent years has been on reducing the supply of illicit substances to the detriment of federal resources being invested in reducing demand. In part, this is the result of program restraints and cutbacks in funding. A renewed federal drug strategy must reflect a more appropriate balance between the goals of reducing the demand for, and the supply of substances.*

√ *Overall, a renewed Canada's Drug Strategy must focus on a health-based approach.*

√ *The observations and recommendations of the Auditor General's report on the federal government's role with respect to illicit drugs clearly reflect what this Committee has heard and seen in the course of its study. A lack of coordination among federal departments and other orders of government, a lack of accountability, a lack of information, a lack of evaluation and a lack of cohesion have indeed hindered the implementation of Canada's Drug Strategy.*

√ *A Canadian Drug Commissioner is needed to ensure the implementation of effective and consistent policy responses to the use and harmful use of substances in Canada and to ensure that federal departments and agencies are fulfilling their obligations in conformity with Canada's Drug Strategy.*

- √ *To be successful. Canada's Drug Strategy must engage partnerships with other orders of government and key stakeholders.*

RECOMMENDATION 1

The Committee recommends that the Government of Canada reaffirm its commitment to addressing the use and harmful use of substances and dependence, by developing, in consultation with provincial/territorial governments and key stakeholders, a renewed, comprehensive, coordinated and integrated Canadian drug strategy to address the use of illicit substances and licit (or legal) substances such as alcohol, tobacco, inhalants and prescription drugs.

RECOMMENDATION 2

The Committee recommends that a renewed Canada's Drug Strategy include clear, measurable goals and objectives as well as a process for evaluation and accountability, and, with these components in place, that adequate and sustained funding be allocated.

RECOMMENDATION 3

The Committee recommends the appointment of a Canadian Drug Commissioner, statutorily mandated to monitor, investigate and audit the implementation of a renewed Canada's Drug Strategy and to report and make recommendations annually to Parliament, through the Speaker of the House of Commons.

RECOMMENDATION 4

The Committee recommends that the Minister of Health be mandated to coordinate the multi-departmental implementation of a renewed Canada's Drug Strategy and to respond to the Canadian Drug Commissioner's report within 90 days in an annual statement to the Standing Committee on Health, through the House of Commons.

RECOMMENDATION 5

The Committee recommends the Canadian Centre on Substance Abuse, as an independent non-governmental organization, be given the mandate to develop, in consultation with federal, provincial and territorial governments and key stakeholders, the goals, the objectives, the performance indicators and the strategic plan for a renewed Canada's Drug Strategy, which shall be comprehensive, coordinated and integrated.

CHAPTER 4: RESEARCH AND KNOWLEDGE

> *Research and other methods of knowledge development must form the foundation of policy and program development. Analysis of this information and data leads to consideration of policy alternatives and goals, the determination of appropriate programming interventions, the setting of performance measures, and the allocations of resources.*[99]

Governing bodies depend on the availability of reliable up-to-date information to design effective supply and demand reduction policies. Research and surveys on the nature, prevalence and trends regarding the use and harmful use of substances help policy-makers gain an insight into the complex social and health related issues. Although the current Canada's Drug Strategy recognizes the importance of knowledge and research in developing and implementing public policy, the federal government has spent very little since 1997 on research related to the use and harmful use of substances.

Early in its investigation, the Committee became conscious of the lack of up-to-date reliable Canada-wide data on substance use patterns and law enforcement activities. Without such data, developing proactive strategies to respond to emerging trends is difficult, if not impossible. The vast majority of witnesses appearing before the Committee reinforced these findings, indicating that there is an urgent need for more and better Canada-wide and regional data on substance use in Canada. Data on addictions in Aboriginal communities, on and off reserve, and on the misuse of prescription drugs is basically non-existent. Limited information on possible cases of prescription drug misuse may be produced through provincial monitoring programs, but there is no federal database gathering such data. A number of provinces conduct regular surveys on substance use among the general population and among students (e.g., Ontario Student Drug Use Survey which has been collecting data since 1977) but each province uses different methodologies, which make it impossible to compare data. We also have very little information on the social and health costs associated with the use and harmful use of substances. For example, Canada-wide data on overdose deaths is not being collected; however, such data would be an important indicator of the extent of harm caused by the use of some psychoactive substances. The most recent study on the costs of substance abuse to society dates back to the study published by the Canadian Centre on Substance Abuse in 1996, using 1992 data.[100] Law enforcement statistics are also lacking. Only partial statistics are available on drugs seized in Canada. There are no national statistics on illicit drug convictions and sentencing in Canada. The existing provincial statistics that are reported are limited in detail.[101]

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[99] Dann Michols, Assistant Deputy Minister, Testimony before the Committee, August 28, 2002.

[100] Eric Single et al., *The Costs of Substance Abuse in Canada*, Canadian Centre on Substance Abuse, 1996.

[101] British Columbia, Manitoba, New Brunswick and Nunavut do not provide adult criminal court information to Statistics Canada.

> *While the national statistics on police charges break down the number of drug charges by both type of substance (for example, heroin, cocaine, and cannabis) and act (for example, possession, trafficking, importation, and cultivation), the statistics on convictions are broken down into only two categories — possession and trafficking.*[102]

Health Canada agreed that knowledge of current Canadian trends and patterns of use and harmful use of substances is poor and that data collection has been, for the most part, piecemeal and sporadic. They reported, "there are no funds dedicated to national monitoring of rates of use of illicit drugs in Canada."[103] In fact, Health Canada stated, "in 1998-1999, the U.S. government awarded six times as much money to support addictions research being conducted in Canada as did the Canadian government."[104] This was reiterated by a number of researchers who testified before the Committee, including Eric Single, professor of public health sciences at the University of Toronto and senior research associate at the Canadian Centre on Substance Abuse, who stated:

> *Despite the fact that the federal government receives more than $3 billion a year from alcohol and tobacco taxes alone, the U.S. government spends significantly more on substance abuse research in Canada — this is the substance abuse problems of Canadians being researched by Canadians. The U.S. government spends six times as much on research on our drug problems than the Canadian government does. These cutbacks have led to a tremendous loss. We've lost almost all of our major senior scientists. I'm feeling quite lonely. Young, promising researchers have been driven to work in other countries or other fields.*[105]

The gaps in knowledge were also acknowledged by the Office of the Auditor General of Canada, which completed a study on the role of the federal government with respect to Canada's Drug Strategy.

> *Information on the extent of the drug problem is either restricted, outdated or unavailable. This also applies to general basic information and management information.*
>
> *… There is no complete and consolidated information on what federal departments are spending on addressing illicit drugs, either reducing supply or reducing demand. This is basic information essential to managing any program.*[106]

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[102] Office of the Auditor General of Canada, *2001 Report of the Auditor General*, Chapter 11 — Illicit Drugs: The Federal Government's Role, Canada, 2001, p. 15.

[103] Health Canada, *Response to the Committee*, 2002, p. 18-19.

[104] Ibid., p. 7.

[105] Eric Single, Testimony before the Committee, November 7, 2001.

[106] Michael McLaughlin, Deputy Auditor General of Canada, Office of the Auditor General of Canada, Testimony before the Committee, February 6, 2002.

1. NATIONAL SURVEYS

The most recent national surveys that dealt specifically with the prevalence of alcohol and other licit and illicit substance use among the general population were conducted in 1989 and 1994. As well, the Canadian Campus Survey, conducted in the fall of 1998, provided national data on alcohol and other substance use, alcohol problems, consequences of alcohol use, and the context and characteristics of drinking occasions of undergraduate students. Until recently, national health surveys of the general population (e.g., National Population Health Survey) have included questions on the use of alcohol and tobacco, the use of prescription drugs, and at times alcohol dependence, but not on the use of illicit substances.

A new survey, the Canadian Community Health Survey (CCHS), will temporarily remedy this situation and provide, at the end of summer 2003, data on substance use and dependence including illicit substances among persons aged 15 years and older living in private occupied dwellings in ten provinces. This survey has been developed to provide regular Canada-wide estimates of major mental health disorders and problems. The CCHS has a two-year collection cycle "comprised of two distinct surveys: a health region-level survey in the first year with a total sample of 130,000 respondents and a provincial-level survey in the second year with a total sample of 30,000 respondents."[107] Each second year of the survey cycle is designed to focus in-depth on a particular topic. In 2002, the topic selected was mental health and well-being which included numerous questions on the use and harmful use of substances, and dependence, including solvents and steroids. Currently, there are no plans to survey the use and harmful use of substances other than alcohol and tobacco in the next cycle. Questions on alcohol, harmful use of alcohol, alcohol dependence, and smoking are common content and will be part of every cycle. The Committee believes that consideration should be given to integrating questions on licit and illicit substances in every cycle of the Canadian Community Health Survey.[108]

Another potential source of information will be the Human Resources Development Canada (HRDC) National Longitudinal Survey of Children and Youth. This survey was designed in 1994 to collect data at two-year intervals on a representative sample of Canadian children and youth from 0 to 25 years of age.[109] The objective is to "provide data to support longitudinal analysis on the prevalence of various biological, social and economic characteristics and risk factors among children and youth."[110] The first cohorts included 22,831 children aged 0 to 11. Information was collected from the parents, the children themselves (for children of 10-11 years of age), schoolteachers and principals. Data on young people aged between 10 and 17 is expected to be available in the spring of 2003 and will include some information on first-time use of substances. This survey has the potential to develop empirical evidence and policy relevant information for the development of prevention and education programs by isolating predictive factors and distinguishing critical points of intervention for changing a trajectory toward substance use.

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[107] Statistics Canada, *The Canadian Community Health Survey (CCHS): extending the wealth of health data in Canada*, available online at www.statcan.ca/english/concepts/health/ccshinfo.htm.

[108] From a research point of view, this survey has numerous advantages: large sample; attention paid at representativeness of youth population; provision of data at the provincial and sub-provincial (health region) levels; good dissemination plan that includes the production of a microdata file that can be shared with the provinces, territories and Health Canada and, in addition, a public use microdata file; international comparability with similar data produced by the World Health Organization; and a focus on community health likely to give access to a broader sample of the population than a survey addressing strictly the use and harmful use of substances.

[109] The survey excludes Aboriginal children living on reserves and children in institutions.

Canada-wide surveys offer insight into the use and harmful use of substances that is essential to an overall assessment of the problem. However, these data sources, with the exception of the new Canadian Community Health Survey, are for the most part of limited use at the provincial and local levels. Canada-wide surveys supplement other available data sources but certainly do not replace valuable provincial and local data sources on the use and harmful use of substances. Nonetheless, more in-depth research and knowledge into public health and public safety issues related to the harmful use of substances, and dependence, is needed to inform policy decisions and to address the multitude of related problems.

> *Our foundation would point out, however, that we need much more than research into drug use patterns. While this and other epidemiological data are essential to good policy development, no less important is research into best practices and program effectiveness. In order to move toward an evidence-based system, policy-makers, program developers, and funders all need access to quality data.*[111]

Federal funds, albeit limited, support in part the development, coordination and dissemination of research and knowledge on the use and harmful use of substances primarily through work done by the Canadian Centre on Substance Abuse (CCSA), the Canadian Institutes on Health Research (CIHR) and other federal initiatives such as the Addictions Research Centre (ARC) of Correctional Service Canada.

2. RESEARCH ON THE USE AND HARMFUL USE OF SUBSTANCES AND KNOWLEDGE MANAGEMENT

(a) Coordinated Efforts at the Canadian Centre on Substance Abuse

The Canadian Centre on Substance Abuse (CCSA), funded in part by Health Canada, is the main agency through which existing data on the use and harmful use of substances is being collected and disseminated across Canada. "The CCSA monitors research developments, participates in research forums and seeks to inform key stakeholders of innovative and relevant developments, which may bear on policy and programming."[112] The CCSA is also a substance abuse and addictions affiliate for the Canadian Health Network.

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[110] Canada's National Longitudinal Survey of Children and Youth Web site at: www.hrdc-drhc.gc.ca/sp-ps/arb-dgra/conferences/nlscyconf/flyer-e.shtml.

[111] Dan Reist, President, Kaiser Foundation, Testimony before the Committee, December 3, 2001.

Health Canada supports the work done by the CCSA in the area of information and knowledge management, and recognizes the need for more funding for research coordination. In the interim of a federal commitment to substantially fund Canada's Drug Strategy, Health Canada took an expediential measure in March 2002 and increased funding for the CCSA from $500,000 per year to $1.5 million for each of the next three years to allow the Centre to expand its activities in support of policy development. However, this level of funding does not allow the CCSA to adequately fulfill the mandate it was given by Act of Parliament in 1988.[113]

The Canadian Centre on Substance Abuse has spearheaded a number of important research and knowledge networks and services over the last decade and currently is involved in the management or coordination of the following:

- The National Clearinghouse on Substance Abuse, including a Fetal Alcohol Syndrome/Fetal Alcohol Effects (FAS-FAE) Information Service and numerous databases related to substance use such as a database of Canadian addictions researchers;

- The Virtual Clearinghouse on Alcohol, Tobacco, and Other Drugs (VCATOD);

- The Canadian Community Epidemiology Network on Drug Use (CCENDU);

- The Health, Education and Enforcement in Partnership network;

- The Canadian Substance Abuse Information Network (CSAIN);[114]

- The CCSA National Working Group on Addictions Policy; and

- The Canadian Executive Council on Addictions (CECA).

Some Committee members expressed concerns over the proliferation of virtual and non-virtual research networks currently being coordinated by the CCSA. Unfortunately, the Committee did not have the opportunity to assess the effectiveness of these research and knowledge networks and services. The Committee believes that under a renewed Canada's Drug Strategy, all components of the strategy should be subject to comprehensive evaluations to ensure effectiveness, increase accountability and avoid duplication of services. Furthermore, the mandate of the proposed Canadian Drug Commissioner will ensure that federal dollars and resources will be appropriately allocated and reallocated if need be.

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[112] Canadian Centre on Substance Abuse, *CCSA-CCLAT 2000-2001 Annual Report*, available online at www.ccsa.ca/AR2001/index2.htm.

[113] The mandate of the Canadian Centre on Substance Abuse is presented in Chapter 3 of this report.

[114] CSAIN was launched by the CCSA in 1992 and provides a network where resource centres, major libraries and researchers can share information on addictions in Canada.

According to published documents and testimony before the Committee, here are some examples of activities undertaken by research and knowledge management networks currently being coordinated and/or managed by the CCSA.

(i) National Clearinghouse on Substance Abuse

Since 1991, the National Clearinghouse on Substance Abuse has been providing information to a variety of stakeholders, agencies, governments and anyone interested in learning more about the issues related to the use and harmful use of substances. The clearinghouse "complements the work of the Canadian Substance Abuse Information Network (CSAIN), and responds mainly to requests that are national in scope."[115] The clearinghouse offers two information services: the General Reference Service, and the FAS/FAE Information Service. In order to respond to information requests and to enhance dissemination of Canadian resources, the clearinghouse has "a very extensive collection of what they call fugitive or grey literature, which is literature that has not been published in peer-reviewed journals. They are difficult-to-obtain documents that researchers typically like to look at and draw from, as they go about their research."[116] The FAS/FAE information service, funded in part by the Brewers Association of Canada and the Association of Canadian Distillers, provides a toll-free telephone line to an information specialist and access to "a special collection, bibliographies, a Web site, and links to support groups, prevention projects, resource centres and experts on FAS/FAE."[117]

The clearinghouse has been at the forefront in making information available on the Internet through the CCSA Web site, since January 1995. The Web site offers access to numerous databases including a national bibliographic database of Canadian publications dealing with the harmful use of substances, a number of directories of addiction organizations and agencies, a database of addictions researchers in Canada as well as a topical database on Hepatitis C and injection drug use. Finally, the Web site also offers access to a series of research publications published by the CCSA on a multitude of issues related to the use and harmful use of substances.

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[115] Canadian Centre on Substance Abuse, *CCSA-CCLAT 2000-2001 Annual Report*.

[116] Michel Perron, Chief Executive Officer, Canadian Centre on Substance Abuse, Testimony before the Committee, October 25, 2001.

[117] Canadian Centre on Substance Abuse, *CCSA-CCLAT 2000-2001 Annual Report*.

(ii) The Virtual Clearinghouse on Alcohol, Tobacco, and Other Drugs (VCATOD)

The Virtual Clearinghouse on Alcohol, Tobacco and Other Drugs, funded by the Department of Foreign Affairs and International Trade, is a trilingual Internet site (English, French and Spanish), which offers a single portal to worldwide research produced by recognized organizations that provide credible information related to the use and harmful use of substances. The Virtual Clearinghouse also provides a mechanism for online exchanges of information called "threaded" discussions such as discussions on high-risk youth, the state of marijuana research or the state of knowledge about ecstasy which all took place online in 2000-2001.[118]

(iii) Canadian Community Epidemiology Network on Drug Use (CCENDU)[119]

The Canadian Community Epidemiology Network on Drug Use (CCENDU) was established in 1995 as a Canada-wide surveillance system on substance use. It is a counterpart of the Community Epidemiology Working Group in the United States, which has been around for 25 years. According to its own description, CCENDU is "a collaborative project involving federal, provincial, and community agencies, with intersecting interests in drug use, health and legal consequences of use, treatment, and law enforcement."[120] Its stated goals are "to coordinate and facilitate the collection, organization, and dissemination of qualitative and quantitative information on drug use, among the Canadian population at the local, provincial, and national level" and "to foster networking among key multi-sectoral partners, to improve the quality of data being gathered, and to serve as an early warning system concerning emerging trends."[121]

> *Essentially, CCENDU's vision is a partnership to monitor drug trends and associated factors. There are two parts to that vision. One, which I think really captures CCENDU, is the idea of partnership. As I just said, there's partnership at the local, national and international levels. The other part is to monitor drug trends and associated factors, and that's essentially the data part.*[122]

There are currently 12 CCENDU sites across Canada, which are at different levels of development. They all collect data on an annual basis and some submit reports that provide information on the use and harmful use of some substances in a particular region of Canada. These substances are: alcohol, cocaine, cannabis, heroin, sedative-hypnotics and tranquilizers, hallucinogens, stimulants and licit drugs. Information from the sites' reports is incorporated in an overview report, which provides gender specific data on prevalence, treatment, law enforcement activities, morbidity, mortality, HIV/AIDS and Hepatitis C. The network plans to establish five new sites every year in rural and urban settings. CCENDU is also looking at the feasibility of on-reserve data collection, which would fill a huge gap in data on the use and harmful use of substances among the First Nations people.

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[118] Ibid.

[119] Most of the information in this section is taken from the Canadian Community Epidemiology Network on Drug Use Web site at www.ccsa.ca/ccendu/index.htm and the testimony of Colleen Anne Dell, National Coordinator of CCENDU, before the Committee, October 25, 2001.

[120] CCENDU Web site at www.ccsa.ca/ccendu/index.htm.

[121] Ibid.

[122] Colleen Anne Dell, National Coordinator of CCENDU, Testimony before the Committee, October 25, 2001.

An evaluation of CCENDU was completed in 1999 by Alan Ogborne of the Centre for Addiction and Mental Health, on behalf of the Canadian Centre on Substance Abuse, and funded by Health Canada. The evaluation showed that "good progress has been made toward the original objectives, particularly in regard to the establishment of a national framework; the development of local networks involving policy developers; the routine gathering, processing and dissemination of various types of data; and, increasing awareness of the limitations of existing data".[123] The main concerns were the quality of the data available to CCENDU, the need for greater consistency in data sources, as well as the need for more rapid dissemination. The evaluation report concluded:

> *CCENDU has the potential to ensure that alcohol and drug-related policies and programs are reality-base and effective. Reports from CCENDU could be of use to all those with an interest in alcohol and drug-related problems, including local and national policy-makers, the general public and those most affected by these problems. CCENDU addresses a widely held concern for better information on health issues and programs. CCENDU can also enhance Canada's capacity to respond to requests from the World Health Organization, the UN Commission on Narcotic Drugs and other international agencies concerned with alcohol and drug problems.*[124]

The evaluation report recommended the continuation of CCENDU as a national project with further evaluation after three more years and federal financial support for the national coordination function through the Canadian Centre on Substance Abuse.

CCENDU has made progress toward addressing the main concerns raised in the 1999 evaluation. They are currently working with their partners to establish standardized data sources and collection techniques, which will increase comparability of data across Canada. Timeliness of reporting remains an obstacle but CCENDU is addressing this issue by proceeding with the development of a Web-based format for regular reports and an online community where site coordinators will be able to share information. While CCENDU continues to face difficulties regarding funding of their network, the CCSA has given it a high priority and has recently hired a national research advisor to provide leadership to the network.

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[123] Ogborne, Alan, An *evaluation of the Canadian Community Epidemiology Network on Drug Use (CCENDU)*, March 1999, available online at www.ccsa.ca/plweb-cgi/fastweb.exe?getdoc+view1+General+339+ 8++CCENDU.

[124] Ibid.

(iv) Health, Education and Enforcement in Partnership[125]

The CCSA also coordinates the Health, Education and Enforcement in Partnership (HEP) network since its establishment in 1994. According to its own description, HEP is a network of key stakeholders from the health, education and enforcement fields committed to the development of collaborative initiatives to address issues related to substance use and abuse.

HEP is led by a Steering Committee, which includes representatives from the Canadian Centre on Substance Abuse, Health Canada, Correctional Service Canada, the Canadian Association of Chiefs of Police, the Department of the Solicitor General (Secretariat and RCMP), the Department of Justice (including the National Crime Prevention Centre), the National Parole Board, the Federation of Canadian Municipalities, Alcohol and Drug Concerns,[126] the Canadian Association of Principals and the Student Life Education Company (BACCHUS). The Steering Committee hosts an annual meeting, which brings together members of the Federal/Provincial/Territorial Committee on Alcohol and Other Drug Issues, the Canadian Association of Chiefs of Police, the RCMP Drug Awareness Service and others, to exchange information, learn from one another and develop networks to pursue informal relationships throughout the year.

Activities of the HEP network include:

- Information sharing on substance use and abuse within the network and externally;
- Identification of policy issues and sharing of positions on relevant topics;
- Multidisciplinary and multi-sectoral policy and program responses to current research;
- On-going communication via coordinated newsletters/information updates;
- List-serv organization through the CCSA Web site; and
- Collaboration of network partners to maximize the effectiveness of their efforts.

According to the background information available on the HEP Web site, the HEP network is rooted in the concept of seeking a balanced approach between supply reduction and demand reduction when addressing the numerous issues related to substance use and abuse. Its objectives are to promote better cooperation between stakeholders in the public health, education and enforcement fields, better sharing of information, better use of resources by preventing duplication and encouraging partnerships, and to contribute to policy and programming in the substance abuse field.

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[125] The information in this section is taken from the Health, Education and Enforcement in Partnership Web site, at www.ccsa.ca/HEP/index.htm.

[126] Alcohol and Drug Concerns is a national charitable organization dedicated to reducing the harms of substance abuse. They focus specifically on issues relevant to young people 12 to 15 year olds. More information is available on their Web site at www.concerns.ca/homepage.htm.

(v) National Working Group on Addictions Policy

The CCSA National Working Group on Addictions Policy was established in 1992 to monitor policy issues, develop policy documents and help coordinate policy development across Canada. It brings together representatives from key governmental and non-governmental organizations in the addictions field, as well as academia, research, and policy.[127] Michel Perron, Chief Executive Director of the CCSA, told the Committee that the working group takes on particularly controversial or difficult issues, those which perhaps a particular federal department or provincial government might not want to address on their own.

The working group meets twice a year and members participate at their own expense. Policy discussion documents have been prepared on a variety of subjects, including guiding principles for policy development, syringe exchange, harm reduction, cannabis policy, problem gambling, drug courts and the impact of smoking on drug treatment.

(vi) Canadian Executive Council on Addictions (CECA)[128]

The Canadian Executive Council on Addictions (CECA) was recently established (2002) to provide a forum for leaders in the field of addictions in Canada to influence public policy related to the harmful use of substances, and dependence. Its membership includes senior executives of addiction agencies operating in Canada under a legislated federal or provincial mandate, or a recognized provincial authority, as approved by the board of directors. Current members represent British Columbia, Alberta, Manitoba, and Ontario. The chief executive officer of the Canadian Centre on Substance Abuse sits on the Council as a representative of that organization.

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[127] The meetings of the National Working Group on Addictions Policy are chaired by Eric Single and include respected members such as John Borody (CEO, Addictions Foundation of Manitoba), Laurie Hoenschen (Canadian Society on Addiction Medicine), Louis Gliksman (Director of Social and Evaluation Research, Centre for Addiction and Mental Health), Lisa Mattar Gomez (Health Canada), Perry Kendall (Chief Medical Officer, British Columbia), Christiane Poulin (Professor of Community Health and Epidemiology, Dalhousie University), Ed Sawka (Director of Policy, Alberta Alcohol and Drug Abuse Commission), John Topp (Director, Pavillon Foster, Montreal), and Brian Wilbur (Director, Nova Scotia Drug Dependency Services).

[128] The information in this section is taken from the testimony of members of the Canadian Executive Council on Addictions before the Committee, August 29, 2002.

(vii) Conclusion

The Canadian Centre on Substance Abuse has demonstrated dedication to the fulfillment of its mandate, roles and responsibilities throughout the past 14 years despite major cutbacks in its core funding from the federal government. The Centre has managed through the commitment of its personnel, its own revenue-generating efforts, its capacity to leverage scarce resources into successful initiatives, its ability to form partnerships, and its focus on innovation to establish itself as the lead Canadian agency in the field of addictions.

When the CCSA was established in 1988 it received $2 million from the federal government as initial funding with an understanding that to fully meet the mandate it was given by Act of Parliament, monies would be required beyond this minimum base. Initial funding was also meant to leverage monies from other orders of government and non-governmental agencies involved in the field of addictions. However, with the effective sunset of Canada's Drug Strategy in 1997, federal funding for the Centre was reduced by 75% to $500,000 per year. Its mandate remained the same and demands for CCSA services continued to increase. The recent increase in federal funding to $1.5 million per year does not even bring the CCSA back to its initial 1988 funding.

The Committee acknowledges the work that has been done by the CCSA with very limited resources and recognizes that, given appropriate funding, the Centre has the ability to play an expanded role under a renewed federal drug strategy and to clearly establish itself as the lead agency, both domestically and abroad, on the use and harmful use of substances in Canada. In an attempt to determine a reasonable amount of annual core funding, the Committee determined that, taking inflation into consideration, the initial annual core funding of $2 million promised by the federal government in 1988 would amount to $2,820,755 in 2002 dollars. The Committee further recognizes that the landscape has significantly changed in the last 14 years and that the demands for CCSA services have increased and will continue to do so under a renewed federal drug strategy as this report recommends an expansion of its mandate. The Committee thus recommends that federal funding for the Canadian Centre on Substance Abuse be immediately increased to $3 million so as to ensure that the CCSA has the necessary resources to continue its work and undertake the design of a new federal drug strategy.

(b) The Canadian Institutes of Health Research (CIHR)[129] — Institute of Neurosciences, Mental Health and Addiction (INMHA)

Currently, the Institute of Neurosciences, Mental Health and Addiction (INMHA)[130] is the main institute of the Canadian Institutes of Health Research (CIHR), which allocates research funds to address issues related to the harmful use of substances and dependence. The INMHA allocates funds for a vast array of health concerns that currently include mental health, neurological health, vision, hearing and cognitive functioning. The Institute also supports research to reduce the burden of related disorders through prevention strategies, screening, diagnosis, treatment, support systems and palliation. Addiction prevention policies and strategies is thus one research area among many others that the institute supports.

For example, the CIHR funds a large interdisciplinary health research team comprised of 15 investigators from across Canada, under the lead of Dr. Benedikt Fischer (University of Toronto and Centre for Addiction and Mental Health), to conduct a multi-site cohort study with untreated illicit opiate users in five Canadian cities (Vancouver, Edmonton, Toronto, Montreal and Québec).[131] This team of researchers endeavours to improve illicit opiate research, treatment and policy in Canada. The Committee acknowledges that this type of research is desperately needed and should be encouraged through financial support.

The INMHA, in partnership with the Institute of Aboriginal People's Health, also supported the creation of a National Network for Aboriginal Mental Health Research (NNAMHR). The NNAMHR has received funding from the CIHR for a four-year period to conduct research in partnership with Aboriginal communities and academic researchers and develop research capacity to address the pressing mental health needs and concerns of Aboriginal people in rural and urban settings. This network has the potential to produce much-needed data on the use and harmful use of substances, and dependence, among Aboriginal people. However, the results will not be seen for many years.

Notwithstanding these efforts, many witnesses appearing before the Committee argued that the exceedingly broad mandate given to the INMHA results in a lack of focus on addictions research.

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[129] CIHR is Canada's premier federal agency for health research. Its objective is to excel, according to internationally accepted standards of scientific excellence, in the creation of new knowledge and its translation into improved health for Canadians, more effective health services and products and a strengthened health care system. More information is available on the CIHR's Web site at www.cihr-irsc.gc.ca/about_cihr/overview/who_we_are_e.shtml.

[130] The Institute of Neurosciences, Mental Health and Addiction is one of 13 different institutes within the Canadian Institutes of Health Research, which funds research and training on specific topics of interest to Canadians.

[131] B. Fischer, et al. (2002) OPICAN Cohort study (IHRT/CIHR).

> *The CIHR institute I'm on the board of — neuroscience, mental health, and addiction — is making a very sincere effort to address all these terrible problems of the current research situation regarding addictions. They have a large mandate. They also have to cover mental health, neuroscience, vision problems, and hearing problems. I'm the only member in the substance abuse area on the 15-person board. I'm surrounded by neuroscientists and mental health people. We have to give them a period of time, see how much they accomplish, and then revisit the idea.*
>
> *I still haven't given up the idea that maybe at some point, not far in the future, the next time they decide to rearrange the makeup of the CIHR institutes they will consider a stand-alone institute on addictions. I think the scope of the social and health problems associated with substance abuse alone merits that. It's the approximate cause of one in five deaths in Canada, and it's the reason why many of the underlying determinants of health relate to low levels of population health.*[132]

Given the scope and consequences of problems related to the harmful use of substances in Canada, the Committee believes that the current INMHA should increase its focus on addictions research.

(c) Other Federal Initiatives

The Addictions Research Centre (ARC) was established in November 1999 and officially opened on 18 May 2001. The Centre is responsible for all addictions research and development activities within the mandate of Correctional Service Canada (CSC). It is fully funded by the CSC. Its role is:

- To advance the management of addiction issues in criminal justice toward the goal of contributing to public protection; and
- To enhance corrections policy, programming and management practices on substance abuse through the creation and dissemination of knowledge and expertise.

The ARC has adopted the following goals:

- To meet applied research needs of CSC policy, programming and management practices.
- To build co-operative and complementary relationships with partners.
- To provide a location for internationally recognized researchers to conduct research (i.e., the Centre offers facilities for up to four visiting experts and residential accommodation for up to three people).

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[132] Eric Single, Testimony before the Committee, November 7, 2001.

- To promote research in addictions and corrections.
- To provide research training and development.

Since its opening in 2001, the Centre has conducted research in a number of areas including the unique needs of Aboriginal offenders in relation to the harmful use of substances; special needs of women and gender specific patterns of use and harmful use of substances; fetal alcohol syndrome; evaluation of the effectiveness of intensive support units within correctional institutions; effectiveness of a methadone maintenance program; effectiveness of random and mandatory urine analysis programs; and updating assessments tools used in correctional facilities to determine levels of substance abuse of offenders.[133]

In 2002, the ARC also organized an international forum to discuss research and development priorities related to the use and harmful use of substances within the correctional environment. The Forum was co-sponsored by the Canadian Centre on Substance Abuse and the Centre international de criminologie comparée at the Université de Montréal. It brought together 160 delegates (researchers, correctional managers, program delivery staff and individuals working in the field of substance abuse at the community level) from ten countries.

Finally, there are other federal initiatives supporting research, surveillance and knowledge dissemination related to predictive factors and prevalence of use and harmful use of substances. The Canadian Strategy on HIV/AIDS supports research related to injection drug use as a risk factor for Hepatitis C and HIV/AIDS. The Fetal Alcohol Syndrome/Fetal Alcohol Effects initiative supports the development and dissemination of research and knowledge as it relates to this particular area. For example, the initiative has launched a review of best practices and a situational analysis of research, policies, practices and programs and co-funded a national information service on FAS/FAE through the CCSA National Clearinghouse on Substance Abuse.

3. SETTING RESEARCH PRIORITIES AND RESOURCES

The Committee acknowledges the on-going research activities and the work currently being done with respect to information and knowledge management. However, the Committee observed that there are important gaps in knowledge related to the use and harmful use of substances, that coordination of current activities needs improvement, and that resources allocated to research are inadequate. The Committee concludes that there is a need to increase and better coordinate Canada's research capacity on the use and harmful use of substances and dependence.

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[133] Ross Toller, Director General, Offender Programs and Reintegration, Correctional Service Canada, Testimony before the Committee, October 3, 2001.

Research priorities for evidence-based policy development on the use and harmful use of substances and clear national indicators[134] against which all governmental and non-governmental stakeholders can agree to collect data annually should be set by Health Canada in consultation with the CCSA and other key stakeholders, including users of substances. Resources must be allocated to addictions research if Canada is to meet the challenges brought forth by these complex social and health issues.

4. COMMITTEE OBSERVATIONS — RESEARCH AND KNOWLEDGE

The Committee observed the following:

- √ *There is an alarming lack of information on the nature, prevalence and patterns of use and harmful use of substances and dependence, as well as a lack of coordination of research, data and best practices in Canada.*
- √ *United States and Europe invest a substantial amount of resources into addictions research. In Canada, the investment in research pales in comparison. In fact, in recent years the United States government has awarded six times as much money as the Canadian government to support addictions research being conducted in Canada. Furthermore, we should be utilizing world research studies where appropriate.*
- √ *Innovative, outcome-based research on the use and harmful use of substances and dependence, requires sustained, dedicated resources to achieve real breakthroughs in our understanding of substance use in Canada and to design policies and programs that will make meaningful differences in the lives of Canadians, their families and communities.*
- √ *An early warning system must be set up to ensure that when a new synthetic drug or substance is identified on the streets, we have access to information on its production, traffic and use without delay.*

RECOMMENDATION 6

The Committee recommends that biennial cross-Canada surveys be undertaken as part of a renewed Canada's Drug Strategy to determine the nature, prevalence and trends of all substance use in Canada.

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[134] For example, to monitor the use and harmful use of substances, and dependence, indicators commonly used are: the number of people who have used a substance in the past 12 months; the number of people in treatment; the number of drug-related overdose deaths; morbidity data; criminal justice data such as the number of seizures of illicit substances and the number of drug-related offences etc.

RECOMMENDATION 7

Considering the urgent need for Canada-wide data on the use and harmful use of substances and dependence, and the costs and benefits of using a regular health survey to gather such data, the Committee recommends serious consideration be given to integrating questions on licit and illicit substances in every cycle of the Canadian Community Health Survey, every two years.

RECOMMENDATION 8

The Committee recommends that the Government of Canada's contribution to the Canadian Centre on Substance Abuse (CCSA) be immediately increased to $3 million, with subsequent annual increases to be determined based on the recommendations of the Canadian Drug Commissioner following an annual review and audit of the needs and activities of the CCSA.

RECOMMENDATION 9

The Committee recommends that the Institute of Neurosciences, Mental Health and Addiction increase its focus on addictions research.

RECOMMENDATION 10

The Committee recommends that the Government of Canada, under a renewed Canada's Drug Strategy, provide Health Canada with dedicated research funds to:

- **Ensure the systematic and regular collection, retrieval and integration of regional, provincial and Canada-wide data on the use and harmful use of substances, and dependence;**
- **Sustain research initiatives on key issues related to the use and harmful use of substances, and dependence; and**
- **Increase funding of addictions research through the Institute of Neurosciences, Mental Health and Addiction of the Canadian Institutes of Health Research.**

RECOMMENDATION 11

The Committee recommends that Health Canada, in consultation with the Canadian Centre on Substance Abuse and key stakeholders, including substance users, identify research priorities to be supported by dedicated research funds under a renewed Canada's Drug Strategy.

CHAPTER 5: THE USE AND HARMFUL USE OF SUBSTANCES: PUBLIC HEALTH ISSUES

> *Too often, drug users are portrayed as self-indulgent, morally corrupt, and generally responsible for the social and economic problems of our urban centers. Such scapegoating is entirely counterproductive and clouds the real issue. Specifically, drug use is primarily a public health issue and should be approached with prevention and treatment.*[135]

> *HIV-AIDS and hepatitis are two diseases that are part of a declared public health emergency that has been called in the downtown east side, yet you have failed to act and, in doing so, have literally sentenced me and my brothers and sisters to death. HIV-AIDS prevalence rates rival those of sub-Saharan Africa, and we're 100% saturated with hepatitis C — I repeat, 100%. There's nobody down there who doesn't have it. These diseases and others such as tuberculosis will eventually cost the health care system untold millions of dollars.*

> *What is particularly maddening is that it is all preventable. Overdose rates rival those anywhere in the free world. We lost 147 last year. In broad daylight last Saturday we lost a 16-year-old Aboriginal youth, a young male with a whole life ahead of him. It's becoming unacceptable. What we need here is action. The mayor's got it right; we have the framework for action. It's been written, and it includes all four — enforcement, prevention, treatment, and harm reduction strategies — but it's time to act.*[136]

The Committee, in agreement with the vast majority of witnesses appearing before it, believes that the use and harmful use of substances are primarily public health issues. Some Canadian urban centres are the scenes of what some witnesses characterize as "public health disasters." The most well-known and visible example is certainly the Vancouver Downtown Eastside where the Vancouver-Richmond Health Board declared a public health emergency in 1997 in response to the prevalence of HIV among injection drug users. Montreal and Toronto are also seeing soaring rates of disease and death among injection drug users in their communities. The public health crisis is on-going and cannot be ignored. Prevention, education, treatment and rehabilitation, and harm reduction are all elements of an integrated approach based on a public health model that must be implemented to address this crisis. To be successful, all partners involved in the field of addictions across Canada including provincial, territorial, and municipal authorities, as well as non-governmental agencies, must endorse and implement a public health approach.

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[135] Dr. Mark Tyndall, Director of Epidemiology, B.C. Centre for Excellence, University of British Columbia, Testimony before the Committee, December 3, 2001.

[136] Dean Wilson, Spokesperson, Vancouver Area Network of Drug Users, Testimony before the Committee, December 5, 2001.

1. PREVENTION AND EDUCATION

> One of the things that is sorely lacking in this country is prevention and education. If you want to talk about dollars and cents and where your investments are best levered, that is certainly the area. The federal government does a great deal of work in tobacco reduction. We see Elvis Stojko skating around at the Olympics, and that is wonderful. We don't hear anything about alcohol or drug abuse prevention.[137]

Research has demonstrated that a high number of young people will experiment with tobacco, alcohol, and/or illicit substances. However, "there are some who don't use, some who use, and some who use to the extent of experiencing problems."[138] The social, health and economic costs of the harmful use of substances and dependence have clearly been established.[139] Preventing the onset of substance use, reducing the risks of a progression from use to harmful use, educating young people who are engaging in substance use about safer use, and minimizing the harmful effects of excessive substance use and dependence are concerns shared by the vast majority of witnesses as well as by members of the Committee. All agree that prevention and education are key elements of Canada's Drug Strategy.

> *Prevention is a vital part of any drug strategy. We must embrace it not just with words, but also with concrete steps to ensure it is put in place adequately, consistently, and with the conviction needed to continue it over the long term. Prevention forms not only the most positive part of any drug strategy, any comprehensive approach to drugs, but it also is the most cost-effective component.*[140]

How do we define prevention? Prevention is a broad concept that may best be defined in terms of a continuum of activities targeted at different populations, at different times of their lives. There are three basic categories of prevention activities: universal prevention, selective prevention, and indicated prevention.[141]

- **Universal prevention** activities address the entire population, whether they are at risk or not of developing a pattern of harmful use of substances, with the aim of promoting healthy lifestyles and of preventing or delaying the onset of substance use. School programs such as DARE, mass media public awareness campaigns, health warning labels, and laws regulating a minimum alcohol drinking age are all examples of universal prevention measures.

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[137] Michel Perron, President, Canadian Executive Council on Addictions; Chief Executive Officer, Canadian Centre on Substance Abuse, Testimony before the Committee, August 29, 2002.

[138] Dr. Christiane Poulin, Associate Professor, Department of Community Health and Epidemiology, Dalhousie University, Testimony before the Committee, April 17, 2002.

[139] Eric Single et al., *The Costs of Substance Abuse in Canada*, Canadian Centre on Substance Abuse, 1996.

[140] Dr. Colin Mangham, Director, Prevention Source B.C., Testimony before the Committee, December 3, 2001.

[141] The terms universal, selective and indicated prevention were first established in the late 1980s and have now come to replace the terms, primary and secondary prevention. Tertiary prevention refers to treatment.

- **Selective prevention** activities target individuals or groups who are at a significantly higher risk of developing a pattern of harmful use of substances than the average person. Community-based programs that provide mentoring, tutoring, life skills development, alternative recreational activities, and youth groups in drug-affected or low-income neighbourhoods are illustrations of selective prevention initiatives.

- **Indicated prevention** activities target people who use substances and show early signs of harmful use, and are at high risk of developing a dependence on a substance. Outreach programs that engage and work with youth to minimize the harms associated with risky behaviours are good examples of indicated prevention programming.

Dr. Christiane Poulin, associate professor at Dalhousie University and Canada Research Chair in Population Health and Addictions, told the Committee that we also need to look at harm minimization for mainstream teenagers in school to determine if such an approach should be an integral part of school-based drug prevention or drug education.

> *At this point I'm going to bring to your attention the definition that is from Patricia Erickson, who is a criminologist. It was published in the Canadian Medical Association Journal. She breaks it down into a few components of what we think we might mean when we're talking about harm minimization for teenagers in schools. It is education about rather than against drugs — the facts. It's also the facts about the benefits, not just the risks. It is credible, accurate information — no propaganda. It acknowledges the appeal of drugs, why teenagers use them, but also acknowledges the flip side — the risks and the consequences. And finally, it takes into account where a teenager is in his or her development. There's a world of difference between a 12- or 13-year-old and an 18- or 19-year-old in terms of the decisions they can make. An 18-year-old can vote for our prime minister.*
>
> *I've brought you back to the risk continuum at this point because it's the most concrete way we've unearthed here in Nova Scotia by which to consider harm reduction at this point. What we're talking about is that there's a population of teenagers. There are some who don't use, some who use, and some who use to the extent of experiencing problems. We need to take care of all teenagers from where they are. The idea is to bring teenagers back from the high end of the continuum, the red area, toward the green. Some teenagers will never be abstainers, but they do not need to face such dire consequences as some of them might be currently facing.*[142]

The Committee applauds the innovative research currently being conducted by Dr. Poulin, and others, in the areas of prevention and education programming for young Canadians and believes that such research should continue and be supported under a renewed Canada's Drug Strategy.

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[142] Dr. Christiane Poulin, Associate Professor, Department of Community Health and Epidemiology, Dalhousie University, Testimony before the Committee, April 17, 2002.

Notwithstanding that innovative research, the Committee agrees with the majority of witnesses who appeared before it deploring the lack of funding and resources being spent on prevention in Canada. This is shocking to many witnesses as Canada's Drug Strategy identifies prevention as one of the most cost-effective interventions. Dr. Jody Gomber, then-Director General of the Drug Strategy and Controlled Substances Programme within Health Canada, told the Committee that very limited resources are dedicated to prevention programming as prevention and education activities are, by and large, within provincial jurisdiction.

> *We actually spend very little. Again, thinking about who all of the players are in Canada's drug strategy, a large part of prevention activity is provincial. It becomes the province's responsibility through the school system. It becomes the province's responsibility through a number of other community kinds of organizations. So we spend very little ourselves on prevention.*[143]

However, Health Canada supports some prevention activities through other initiatives within its portfolio. These prevention activities target high-risk populations such as Aboriginal people, women, children, and youth. They also address specific public health concerns such as preventing HIV/AIDS, Hepatitis C and Fetal Alcohol Syndrome/Fetal Alcohol Effect (FAS/FAE).[144] Best practice documents have been published and distributed to these high-risk groups.[145]

Universal prevention, which addresses the determinants of health, is done mainly through "Early Child Development Initiatives" (e.g., Community Action Program for Children, Canada Prenatal Nutrition Program, and Aboriginal Head Start). In 1999, the federal government allocated $11 million over three years for the expansion of the "Canada Prenatal Nutrition Program" to allow for a sustained focus on FAS/FAE and improve the health of pregnant women. Some of these funds were used to launch a Canada-wide awareness campaign on FAS/FAE in collaboration with provincial and territorial governments. The FAS/FAE initiative includes a Canada-wide FAS/FAE Strategic Project Fund offering over $1.7 million for local projects such as FAS training for front-line workers in community-based projects.

The federal government provides public health and health promotion services for First Nations people living on reserves and Inuit. The First Nations and Inuit Health Branch funds more than 500 alcohol and other substance abuse community-based prevention programs targeted at First Nations people living on reserves and Inuit, through the National Native Alcohol and Drug Abuse Program. As well, the 2001 federal budget allocated $185 million over two years to improve the well-being of Aboriginal children. Some of these funds will be used to implement the Aboriginal Head Start program and others to intensify the efforts to reduce the incidence of FAS/FAE on reserves.[146]

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[143] Dr. Jody Gomber, Director General, Drug Strategy and Controlled Substances Programme, Healthy Environments and Consumer Safety Branch, Health Canada, Testimony before the Committee, October 3, 2001.

[144] In Canada, at least one child is born with FAS every day. Up to 3 in every 1,000 babies are affected by FAS, and more in some Aboriginal communities.

[145] Examples of such documents include: *Preventing Substance Use Problems Among Young People — A Compendium of Best Practices*; *Best Practices — Fetal Alcohol Syndrome/Fetal Alcohol Effects and the Effects of Other Substance Use During Pregnancy*; *Situational Analysis — Fetal Alcohol Syndrome/Fetal Alcohol Effects and the Effects of Other Substance Use During Pregnancy*. These documents are available on Health Canada's Web site as well as on computer diskette, large print, audio-cassette and braille.

With respect to tobacco, Health Canada's Tobacco Control Strategy has a 2001-2002 budget of $54.5 million. The Government of Canada has committed to investing over $480 million in the strategy over the next five years. The funds will reinforce existing programs, while $210 million will be directed to mass media campaigns targeted at Canadians of all age groups, with a special focus on youth and other high-risk populations.

Other federal initiatives in the field of prevention include:

- Over 150 substance-abuse-related community projects funded by the National Strategy on Community Safety and Crime Prevention (NSCSCP) across Canada since 1998 (i.e., many pilot projects reach out to and support youth at risk, and Aboriginal children and youth). It is estimated that $1 million was spent on such projects in the year 1999-2000.[147]

- The Royal Canadian Mounted Police (RCMP) Drug Awareness Service coordinates the delivery of programs such as DARE; PARTY; Drugs and Sports; Two Way Street; Parents, Kids and Drugs; Drugs in the Workplace; Aboriginal Shield; and Racing Against Drugs.[148] It is estimated that the RCMP spent $4 million on its drug awareness service in 1999-2000.[149] The RCMP has 31 federal, full-time staff that oversee the coordination of drug awareness presentations across Canada. "Of those, 14 were provided through Canada's Drug Strategy".[150]

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[146] The Aboriginal Head Start Urban and Northern Program is an early intervention program focused on meeting the early developmental needs of young Aboriginal children living in urban centres and large Northern communities.

[147] Office of the Auditor General of Canada, *2001 Report of the Auditor General of Canada*, Chapter 11 — Illicit Drugs: The Federal Government's Role, 2001.

[148] Information on these programs is available on the RCMP Web site at www.rcmp-grc.gc.ca/das/default_e.htm.

[149] Office of the Auditor General of Canada, *2001 Report of the Auditor General of Canada*, Chapter 11 — Illicit Drugs: The Federal Government's Role, 2001.

[150] Chief Superintendent R.G. (Bob) Lesser, Officer in Charge, Drug Enforcement Branch, Federal Services Directorate, Royal Canadian Mounted Police, Testimony before the Committee, October 3, 2001.

- Correctional Service Canada administers substance abuse programs in federal correctional facilities, at an estimated cost of $8 million for the year 1999-2000.[151] Recognizing the vast majority of inmates will be returning to the community, CSC considers many of these programs to be preventative in nature.[152]

The DARE program is the most well-known school-based program in Canada.[153] The Committee heard a significant diversity of opinion on whether and to what extent police have a role to play in delivering drug education and awareness programs in the community. Witnesses from several police forces spoke of their commitment to providing drug awareness programs within their local schools and clearly stated that they believe it to be an important service to the community, as well as a valuable opportunity to establish a relationship with youngsters at an early and impressionable age. By contrast, several witnesses challenged the effectiveness of the DARE program criticizing what they characterized as a "just say no" message that discourages honest discussion of the risks of illicit substance use, particularly among older students. The RCMP indicated that the DARE program is currently being redesigned to respond better to the needs of different age groups. Others argued that there was a need for prevention research and evaluation of prevention initiatives to ensure that drug education and awareness programs do not do more harm than good. An evaluation of the effectiveness of the DARE program in preventing the onset of substance use and in reducing the use and harmful use of substances among teenagers is on-going.[154]

A number of witnesses appearing before the Committee commented on the low level of public awareness related to the use and harmful use of substances. They suggested that there is not enough information or that the available information is not comprehensive or evidence-based.

Concerns were also expressed over the effectiveness of a "just say no" message to drugs, since our society is rife with commercials advocating a "pill" for every problem. The Committee believes, in agreement with many witnesses appearing before it, that prevention and education activities must address the complexity of appropriate and inappropriate substance use.

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[151] Office of the Auditor General of Canada, *2001 Report of the Auditor General of Canada*, Chapter 11 — Illicit Drugs: The Federal Government's Role, 2001.

[152] Ross Toller, Director General, Offender Programs and Reintegration, Correctional Service Canada, Testimony before the Committee, October 3, 2001.

[153] The Drug Abuse Resistance Education (DARE) program was developed in the United States. It is usually introduced to children in elementary schools in the 5th or 6th grade. A trained officer delivers the program one day per week for seventeen weeks directly in the classroom. The DARE program's objective is to teach kids how to resist drugs and violence by teaching them the personal skills and techniques necessary to handle peer pressure and influence from the media. The DARE curricula are available online at www.dare.com/Curriculum/Default.asp?N=Curriculum&M=10&S=0

[154] Debra Williams, Chair, DARE Evaluation Committee of Alberta, Testimony before the Committee, May 23, 2002.

Finally, some witnesses expressed concerns over the lack of training on issues related to the harmful use of substances currently being offered to service providers, health professionals and others involved in this area. They suggested more accurate information and appropriate training would have a positive impact on prevention efforts as well as on the delivery of addictions services.

The Committee, in agreement with the vast majority of witnesses appearing before it, believes that preventing the use and harmful use of substances can have a significant impact on the safety, security, health and overall quality of life of all Canadians. Consistent, long-term, comprehensive prevention efforts are effective. The tobacco control, and drinking and driving prevention initiatives are cases in point.

> *Prevention does work. We know that prevention works because we have seen it in other areas. If you look at the drinking and driving campaigns, the campaigns to get people to wear seat belts and to stop smoking, these are examples of successful prevention campaigns. Every time I see commercials on TV and some of the other efforts in that area, I wonder why we don't see the same kind of thing aimed at substance abuse prevention. We have never had that kind of a coordinated effort.*[155]

The Committee believes that the implementation of Canada-wide mass media public awareness campaigns should be a priority of the Government of Canada. The campaigns should focus on promoting healthy lifestyles and educating the public about various licit and illicit substances and their health effects. There must also be a requirement to monitor the effectiveness of such campaigns, bearing in mind that preventing the use and harmful use of substances is a long-term process and that positive outcomes will not be evident for many years to come.

The Committee also believes that prevention and education strategies should be coordinated with provincial, territorial, and municipal authorities, as well as community-based organizations, and involve various stakeholders from health, education and enforcement services as well as parents and young people. The aim of these initiatives should be to enhance community capacity, by strengthening local public health infrastructures, so as to ensure the sustained delivery of prevention programming.

Prevention and education must:

- ➢ be based on scientific evidence and provide accurate information about licit and illicit substances;
- ➢ address both the benefits and the risks associated with substance use;
- ➢ address protective factors, risk factors and resiliency;

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[155] Staff Sergeant Chuck Doucette, Provincial Coordinator, Drug Awareness Services, "E" Division, Royal Canadian Mounted Police, Testimony before the Committee, December 3, 2001.

- be comprehensive and take into consideration the broader determinants of health;
- be clear and consistent;
- be relevant to various stages of life (experts agree that prevention must start at a very early age and must be a sustained effort);
- foster healthy attitudes and choices;
- promote personal responsibility; and
- be delivered by credible messengers.

1.1 COMMITTEE OBSERVATIONS — PREVENTION AND EDUCATION

The Committee observed the following:

- √ *There is a critical need for health-based, realistic education and prevention activities that encourage appropriate decision-making strategies, provide information on all mind altering substances, address the risks of using psychoactive substances, and promote the health and well-being of individuals and communities as a whole.*
- √ *Prevention and education activities should target, as a priority, key groups who are at high risk of developing a pattern of harmful use of substances.*
- √ *Prevention messages should be appropriately targeted to all ages, income and education levels, and populations.*
- √ *The Committee acknowledges that the vast majority of Canadians feel that abstinence is the best way of preventing all types of dependence. Moreover, abstinence enables us to adopt behaviours that are safe and healthy.*
- √ *Canada's Drug Strategy should address the gap in services for Aboriginal people living in urban communities and off reserves.*
- √ *The marginalization and stigmatization of substance users has resulted in what some might call a "conspiracy of silence" around the incidence of substance use and its negative impact on individuals, families and communities. Such a silence explains in part the low level of public awareness related to substance use in Canada. This silence must be broken.*

RECOMMENDATION 12

The Committee recommends that the Government of Canada, under a renewed Canada's Drug Strategy, provide sustained funding and resources to develop and implement health-based public awareness, prevention and education programs related to the use and harmful use of substances and dependence, in collaboration with provincial, territorial, municipal authorities and community-based organizations.

RECOMMENDATION 13

The Committee recommends that the Government of Canada, under a renewed Canada's Drug Strategy, allocate funds to develop and implement effective Canada-wide mass media prevention and education campaigns related to the use and harmful use of substances and dependence.

RECOMMENDATION 14

The Committee recommends that the Government of Canada, under a renewed Canada's Drug Strategy, support the development of up-to-date information on the use and harmful use of substances and dependence, and of appropriate training for the benefit of healthcare professionals and all service providers involved in the field of addictions, in collaboration with provincial and territorial governments.

2. TREATMENT AND REHABILITATION

The harmful use of substances and dependence are complex health problems that cannot be isolated from the social and economic environment in which they evolve. In many cases, individuals who develop a pattern of harmful use of substances also have a history of victimization, sexual and physical abuse, family violence, mental health issues, learning disabilities, school failure, and criminality. As a result, addiction treatment is never simple and must always be seen as part of a continuum of care that includes access to other social services such as affordable housing, education and vocational training.[156] The Committee believes that a holistic, gender-relevant, comprehensive approach, which recognizes the importance of integrated services and partnerships, is an essential component of the delivery of treatment and rehabilitation programs and services.

Treatment and rehabilitation services vary in their approach, philosophy, principles and goals. There are many kinds of treatment addressing the harmful use of substances and/or dependence including medical detoxification, outpatient or day programs, and short or long-term residential treatment. For most service providers, the goal of treatment is lifelong abstinence. However, many service providers specified that for some individuals, abstinence may not be realistic in the short-term and for them the best treatment may simply be crisis intervention and harm reduction, a first step toward establishing a healthier lifestyle. This is particularly true in the case of opiate dependent individuals and those addicted to cocaine, a substance that creates a severe psychological dependence, which is particularly difficult to treat. Substance dependency treatment includes many forms of therapies and/or medications, including methadone for some individuals addicted to opiates. Methadone is the only opioid currently permitted for long-term treatment of opiate-dependent persons in Canada. At this time, heroin maintenance is not an approved option.

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[156] See, among others, the testimony of Dr. Peggy Millson before the Committee, February 18, 2002.

(a) Delivery of Services: The Federal Government's Role

Although the provinces and territories have primary responsibility for the development and implementation of drug and alcohol treatment services, the federal government has a role in funding them through contribution agreements. The provinces and territories provide the majority of funds for alcohol and drug treatment, through taxes, provincial health insurance funds, and federal transfer funds under the *Canada Health Act*. However, some federal programs also contribute dollars to treat substance-dependent individuals. The Office of Canada's Drug Strategy provides $14 million on a cost-sharing basis, through the Alcohol and Drug Treatment and Rehabilitation Program (ADTRP), to the provinces and territories, to increase and expand innovative and effective treatment and rehabilitation programs related to alcohol and other psychoactive substances. This is an important component of Canada's Drug Strategy, which brings all levels of government together to discuss alcohol and other substance issues and to develop best practice documents.

As well, the federal government has a special role in providing health care to First Nations people living on reserves and Inuit. The harmful use of substances is one of the major health concerns among First Nations: 62% of First Nations people aged 15 and over perceive alcohol abuse as a problem in their community, while 48% state that drug abuse is an issue. Solvent abuse by youth is another concern: 22% of First Nations youth, who report solvent abuse, are chronic users.[157] To address some of the issues raised by the harmful use of substances among this population, the National Native Alcohol and Drug Abuse Program (NNADAP) of the First Nations and Inuit Health Branch funds treatment services for First Nations people living on reserves and Inuit. Currently, $70 million are spent every year on this program. The goal of NNADAP is "to support First Nations and Inuit people and their communities in establishing and operating programs aimed at arresting and off-setting high levels of alcohol, drug, and solvent abuse among their target populations living on-reserve."[158]

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[157] This information is taken from the Web site of Indian and Northern Affairs Canada at: www.ainc-inac.gc.ca/gs/soci_e.html.

[158] The terms of reference of NNADAP are available online at www.hc-sc.gc.ca/fnihb/cp/nnadap.

Now in its fifteenth year, the NNADAP includes a network of 54 treatment centres that represent approximately 700 in-patient treatment beds. The vast majority of the NNADAP resources (96%) are managed directly by First Nations through contribution and/or transfer agreements.

> *The program was used by 4,616 clients in 1999-2000. The success rate was 66%. The recidivism rate was 30%. Forty-three percent of the clients are admitted for alcohol abuse, 20% for drug abuse and 24% for drug and alcohol abuse.*[159]

There are nine treatment centres across Canada that address solvent abuse in Aboriginal communities, of which, six have been funded by Health Canada. Eight centres focus on young people between the ages of 12 and 19, and one centre addresses the needs of the 16 to 25 year old population. Together, these centres offer 114 beds across Canada at a cost of $13 million per year. Since their establishment, the centres have operated over the set capacity, treating a minimum of 228 clients each year.[160] Many youths treated in these centres face numerous challenges including a history of not attending school, suicide ideation, family addiction, sexual victimization, family violence, involvement with the justice system, and prior participation in a treatment program. The treatment of solvent abuse is a relatively new area and "Canada is one of the world leaders in trying to find solutions for solvent abusers".[161]

NNADAP treatment centres and the Youth Solvent Abuse Centres participate in an accreditation program developed by the Canadian Council on Health Services Accreditation. Together, they will form "the first network of treatment centres to have full accreditation in any jurisdiction on this continent."[162] The Committee recognizes the value of an accreditation process for addiction treatment facilities, as well as certification for addiction counsellors, and encourages all treatment centres and counsellors to consider the benefits of accreditation and certification.

The Committee would like to express its concern for the welfare of off reserve and urban Aboriginal people and communities, many of whom live in inner city areas and are at high risk for developing a pattern of harmful use of substances and dependence. There is some confusion and controversy regarding which jurisdiction should provide services and programs to this population. The result is that urban and off reserve Aboriginal people have "fallen between the cracks." This situation should be a priority for a renewed Canada's Drug Strategy and may well be resolved by setting up a collaborative model among jurisdictions to specifically target urban Aboriginal people.

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[159] Nick Hossack, Senior Manager, Addictions Team, First Nations and Inuit Health Branch, Department of Health, Testimony before the Committee, February 27, 2002.

[160] Ibid.

[161] John Graham, Executive Director, Charles J. Andrew Youth Restoration Centre, Sheshatshiu, Labrador, Testimony before Committee, April 18, 2002.

[162] Nick Hossack, Senior Manager, Addictions Team, First Nations and Inuit Health Branch, Department of Health, Testimony before the Committee, February 27, 2002.

The federal government is also responsible for the delivery of treatment programs to individuals incarcerated in federal institutions, members of the RCMP, members of the Canadian Armed Forces, and persons who have not lived in a province or territory long enough to receive insured health services.[163] Delivery of treatment for federal inmates and other substance-dependent individuals involved in the criminal justice system is further discussed in Chapter 6.

(b) Shortcomings in the Delivery of Treatment and Rehabilitation Services in Canada

(i) Availability of Treatment

One of the main issues raised by witnesses appearing before the Committee is the delay facing individuals seeking treatment, particularly residential services, as a result of a shortage of funds and treatment beds.[164] Many social, economic and political factors influence accessibility to treatment beds, and it therefore varies across Canada. The Committee was told that residential services for young people who have developed a pattern of harmful use of substances are virtually non-existent. According to a 1997 survey conducted by Health Canada, it is estimated that there were only 207 treatment programs across the country offering specialized services for adolescents.[165]

> *… in the fifth largest city in North America, Toronto, there is no residential treatment for youth. You have to go to Thunder Bay as your closest place. For a family to be involved in their teenager's treatment is paramount, so sending your kid off to Thunder Bay is just not a good option.*[166]

The Committee was also told that treatment is seriously underfunded and that some individuals in crisis may have to wait for two to four months to obtain access to treatment. For less urgent cases, the waiting list may be as long as six months.[167] Service providers agree that it is crucial for individuals to obtain the services they need when they need them. As well, some witnesses suggested that there is a need for more culturally sensitive services for Aboriginal people as well as more gender-sensitive services. Furthermore, transportation to treatment facilities as well as a lack of daycare for children were also mentioned as barriers to obtaining treatment. The Committee believes that when an individual is ready to seek treatment, there should be a minimum of delay before an assessment is completed and an appropriate intervention made available. The Committee further agrees that treatment delivery should be sensitive to socio-economic and gender issues, as well as cultural diversity.

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[163] Gary Roberts and Alan Ogborne (in collaboration with Gillian Leigh and Lorraine Adam), *Profile — Substance Abuse Treatment and Rehabilitation in Canada*, prepared for the Office of Alcohol, Drugs and Dependency Issues, Health Canada, 1999, p. 9, available online at www.hc-sc.gc.ca/hppb/alcohol-otherdrugs.

[164] A 1997 survey conducted for Health Canada estimated that there were only 1,200 substance abuse treatment programs in Canada. Alcohol-dependent individuals constitute the main group of clients of these services. See Gary Roberts and Alan Ogborne (in collaboration with Gillian Leigh and Lorraine Adam), *Profile Substance Abuse Treatment and Rehabilitation in Canada*, prepared for the Office of Alcohol, Drugs and Dependency Issues, Health Canada, 1999, p. 6.

[165] Ibid., p. 20.

[166] Dr. Patrick Smith, Vice-President, Clinical Programs, Centre for Addiction and Mental Health, Canadian Executive Council on Addictions, Testimony before the Committee, August 29, 2002.

[167] For example, see the testimony of Charlaine Avery, Clinical Director, Abbotsford Addictions Centre, before the Committee, December 6, 2001.

Another issue raised by many witnesses appearing before the Committee relates to the lack of rehabilitation and social services to assist youth, adults and families to recover from the effects related to the harmful use of substances and dependence. Employability, housing and other social needs must be addressed in order to avoid relapses into a pattern of harmful use of substances and to increase the number of individuals who will achieve successful rehabilitation. The Committee believes that more attention needs to be paid to the social reintegration of individuals in recovery.

> *There is a need for abstinence-focused subsidized housing that supports the recovery of both men and women. There are often clients on a waiting list for supportive housing. Right now we have ten waiting at Harbour Light who applied for supportive housing beds two months ago and who are still occupying treatment beds that could be filled by clients on the intake waiting list.*[168]

(ii) Challenges in the Delivery of Treatment and Rehabilitation

The Committee was told that the profile of people seeking treatment has changed as individuals are presenting more complex physical and mental health problems in combination with a substance use problem. Poly-drug use is also on the rise. Treating substance-dependent individuals who also suffer from Fetal Alcohol Syndrome and Fetal Alcohol Effects (FAS/FAE) is particularly problematic as service providers indicated they do not have the resources or the qualified personnel to respond to the special needs of this population.

> *We are seeing more women in treatment as adults from an FAS/FAE background themselves, and so we are looking at ways we can present the material more effectively to them, so that they can understand it. They are certainly coming in with some disabilities, cognitively and behaviourally, participating in traditional psychotherapy and group therapy. They don't do well in that sort of traditional model, and so we are continuing to assess it.*[169]

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[168] Dean Tate, Program coordinator, Salvation Army Harbour Light Centre, Toronto, Testimony before the Committee, February 21, 2002.

[169] Cathy Wood, Manager, Aventa, Testimony before Committee, May 22, 2002 .

According to a 1999 survey, cognitive, social, behavioural and neuro-psychological assessment services for FAS/FAE affected adolescents and adults were only available in British Columbia.[170] Physician training in the diagnosis of FAS/FAE was available in just four provinces (British Columbia, Alberta, Manitoba, Ontario). Furthermore, at the time of the survey, only Manitoba reported having "recently opened a 20-bed residential youth addiction treatment unit that includes specific components for FAS/FAE-affected youth who reside in Winnipeg."[171] The Committee recognizes the challenges facing treatment providers and agrees that more research must be done to identify and/or develop standards of treatment that would better address the needs of multi-problem clients including FAS/FAE affected adolescents and adults.

(iii) Treating Opiate Addiction

A number of witnesses appearing before the Committee indicated that injection drug users, particularly those suffering from HIV/AIDS, are very marginalized and have more difficulty in obtaining access to treatment and rehabilitation programs. It is estimated that 125,000 people inject drugs such as heroin, cocaine, amphetamines, or steroids in Canada. Many injection drug users are HIV positive or have AIDS, and Hepatitis C affects an even greater number. Infectious diseases are particularly prevalent among people who inject cocaine as the "life of the substance" in the body is much shorter than heroin and people may inject up to 30 times a day, thereby increasing the risks of contracting blood-borne pathogens through unsafe injection practices. The overall prevalence of Hepatitis C Virus (HCV) infection is likely 70% to 80% among injection drug users in Canada. Overall approximately 11,000 persons in Canada would be infected with both HCV and HIV in Canada, and 70% of these co-infections would be related to injection drug use.[172]

Prior to 1993, less than 3% of new HIV infections in Canada were related to injection drug use. By 1996, 33.7% of all new reported positive HIV tests among adults were attributed to injection drug use. In 2001, Health Canada reported that this percentage had decreased to 24.6%. As well, 14.4% of all reported adult AIDS cases in 2001 were related to injection drug use, again a decrease from 21.1% in 1998.[173] This downward trend is encouraging, but these percentages remain alarming. Furthermore, there are subsets of the population who are at higher risk of contracting infectious diseases and who are particularly affected by injection drug use.

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[170] C. Legge, G. Roberts, and M. Butler, *Situational Analysis. Fetal Alcohol Syndrome/ Fetal Alcohol Effects and the Effects of Other Substance Use During Pregnancy*, Health Canada, December 2000, p. 17, available online at www.hc-sc.gc.ca/hecs-sesc/cds/splash.htm.

[171] Ibid., p. 23.

[172] Robert Remis, *Brief to the Committee*, February 18, 2002.

[173] Health Canada, *HIV and AIDS in Canada: Surveillance Report to 31 December 2001*, Health Canada, 2002, p. 4-6, available online at www.hc-sc.gc.ca/pphb-dgspsp/publicat/aids-sida/haic-vsac1201/index.html.

> *The problems of injection drug use and HIV and hepatitis C infection affect all Canadians in society. However, some populations have been particularly affected or even devastated by injection drug use and the associated harms. These are women drug users, street youth, prisoners, and Aboriginal people — basically people who are already in many terms marginalized and facing challenges in their lives above and beyond those related to injection drug use, and who are living with chronic illnesses such as HIV and hepatitis C.*[174]

(a) Methadone Maintenance Treatment (MMT)

Some witnesses argued that measures for treating opiate addiction are underdeveloped in Canada. The availability of methadone maintenance treatment (MMT) is said to be insufficient. For example, in Montreal:

> *Fewer than 1,500 persons are currently under methadone treatment, whereas the number of spaces needed to reach 50% of those who could benefit from treatment is 2,500. Several hundreds of individuals are currently waiting.*[175]

The shortage of physicians and other healthcare professionals who are willing to provide such treatment is one barrier to the availability of MMT. Some physicians providing MMT are apparently so overwhelmed with their patient load that they are unable to provide adequate counselling and support to these patients. It has been reported that some substance-dependent individuals have had to leave their province of residence to obtain access to MMT programs.

> *We have problems in the Maritimes with having enough physicians who are licensed to prescribe methadone to addicts. I know, with the methadone programs in Halifax, there are patients moving there from New Brunswick and from Newfoundland just to get their methadone, which I think is horrendous. I wouldn't want to leave my community because I required methadone. I think there needs to be a national strategy for delivery.*[176]

Methadone maintenance programs are for many individuals a doorway into treatment and may significantly reduce the social and health costs associated with injection drug use.

> *Methadone is a prescribed, legal heroin substitute that is apparently less habit-forming and is used to make contact with heroin users, stabilize them, and eventually reduce their dependence. The methadone maintenance program reduces the chance of overdose, given that the substance is controlled by a*

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[174] Glenn Betteridge, Member, Canadian HIV-AIDS Legal Network, Testimony before the Committee, February 19, 2002.

[175] Dr. Carole Morissette, Community Health Specialist, Testimony before the Committee, Thursday, June 13, 2002.

[176] Coleen Conway, Manager, Nova Scotia Prescription Monitoring Programme, Testimony before the Committee, August 28, 2002.

> *physician; reduces the transmission of diseases like HIV and hepatitis C; decreases crime associated with the need for drugs; and decreases the consumption of drugs in public.*[177]
>
> *I should probably disclose to the Committee that I'm a methadone prescriber and I'm the chairman of the opiate agonist committee for the American Society of Addiction Medicine, and I'm involved in office-based treatment of opiate dependency with agonists — in other words, methadone and drugs like that — in both Canada and the U.S. I definitely believe the literature supports the use of that drug in the treatment of opiate dependency.*[178]

The majority of Committee members believe that opiate-dependent persons in Canada should have access to methadone maintenance treatment and that such treatment should include primary health care, counselling, education and other social services. The Committee supports the use of methadone maintenance treatment where a specifically trained physician oversees the treatment and where this substitution treatment is part of a structured and carefully monitored recovery program.[179]

(b) Heroin Maintenance Treatment

With respect to heroin maintenance, the Canadian Institutes of Health Research have agreed to fund a three-city heroin trial for drug-dependent individuals resistant to other forms of treatment, set to be undertaken in Vancouver, Toronto and Montreal.[180]

> *As a scientist, and that's what I am, I always look at problems and say, if I apply ingenious or good methods, where does it end up? That's where we're at today on a heroin prescription trial.*
>
> *I have seen the disaster. Twenty percent of all the acute care patients who come into our hospital have addictions. What are we going to do, just let that number roll up? I can tell you now that the treatments are not that effective. We see the same people day in and day out. They come in; they go into, say, psychiatry; three months later they're out; and four months later they're back in. They come into the medical wards with endocarditis or HIV. They come in, are discharged, and come back in.*

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[177] Naomi Brunemeyer, Director of Communications, B.C. Persons With AIDS Society, Testimony before the Committee, December 5, 2001.

[178] Dr. Douglas Gourlay, Pain and Chemical Dependency, Wasser Pain Management Centre, Mount Sinai Hospital Foundation of Toronto, Testimony before the Committee, February 21, 2002.

[179] The College of Physicians and Surgeons of British Columbia oversees the administration of the largest methadone program in Canada. For more information on this comprehensive, well-structured and monitored program, see the testimony of Peter Hickey before the Committee, August 28, 2002.

[180] The details of this proposed heroin trial study can be found in Canadian HIV/AIDS Legal Network, "Medical Prescription of Heroin — A Review" in *Canadian HIV/AIDS Policy and Law Review*, Volume 6, Number 1/2, 2001, available online at www.aidslaw.ca/Maincontent/otherdocs/Newsletter/vol6nos1-22001/heroin.htm.

> *So for me, as a practical person, it's time to break the mould and look at some of these innovations. Try a heroin trial, because the status quo is not acceptable. We have one person a week die of HIV in our hospital. But with the natural history of the disease in the IDUs, we're going to go back to where it was when I came ten years ago, where we'll have a person a day die in my hospital from HIV, and they'll almost all be addicts.*[181]

The majority of Committee members recognize the importance and encourage the implementation of the proposed clinical trials pilot project, known as NAOMI (North American Opiate Medications Initiative), to test the effectiveness of heroin-assisted treatment in Canada. The target population are individuals who are dependent on opiates (in accordance with the criteria of the DSM-IV), who are at least 25 years old, and who have a history of opiate dependence of at least five years, a one-year injection history, and a treatment history of methadone maintenance at least twice in their past. Individuals who have a severe medical or psychiatric condition for whom the administration of opiates would be contraindicated, pregnant women, and people incapable of signing an informed consent to participate in the pilot project are ineligible.[182] The Committee agrees that these trials must include protocols for rigorous scientific assessment and evaluation.

2.1 COMMITTEE OBSERVATIONS — TREATMENT AND REHABILITATION

The Committee observed the following:

- √ *Most service providers and health professionals delivering treatment and rehabilitation services in Canada are dedicated individuals doing a very difficult job under very difficult situations (i.e., lack of resources; lack of training; lack of information).*
- √ *There is a lack of low-threshold services, treatment options, long-term recovery and support services to assist individuals, families and communities across Canada dealing with the harmful use of substances. This is short sighted and a fundamental flaw in our current health system.*
- √ *The root causes of the use and harmful use of substances in high-risk populations, such as Aboriginal communities, must be better understood if we are to appropriately address the challenges facing these populations.*
- √ *Canada's Drug Strategy should specifically target urban Aboriginal youth and communities.*

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[181] Dr. Michael O'Shaughnessy, Vice-President, Research; Director, Centre of Excellence, HIV/AIDS, University of British Columbia, Testimony before the Committee, December 3, 2001.

[182] Canadian HIV/AIDS Legal Network, "Medical Prescription of Heroin — A Review", *Canadian HIV/AIDS Policy and Law Review*, Volume 6, Number 1/2, 2001, available online at www.aidslaw.ca/Maincontent/otherdocs/Newsletter/vol6nos1-22001/heroin.htm.

- √ *A majority of Committee members recognize the importance of the proposed pilot project to test the effectiveness of heroin-assisted treatment for heroin users who have failed to respond to methadone maintenance, and encourage its implementation.*

- √ *Health Canada must play an active role in facilitating, supporting and evaluating the heroin-assisted treatment pilot project.*

RECOMMENDATION 15

The Committee recommends that a renewed Canada's Drug Strategy explicitly recognize the concept of and contribute toward a continuum of care, including low-threshold services, long-term treatment and recovery services, which would integrate the provision of social services as an essential element of treatment and rehabilitation.

RECOMMENDATION 16

The Committee recommends that a renewed Canada's Drug Strategy include abstinence as one of the wide range of successful treatment options that currently exist.

RECOMMENDATION 17

The Committee recommends that a renewed Canada's Drug Strategy explicitly recognize the need to provide treatment services in a timely manner and that these services be sensitive to socio-economic, gender and cultural diversity.

RECOMMENDATION 18

The Committee recommends the development and delivery of treatment services adapted for individuals with Fetal Alcohol Syndrome/Fetal Alcohol Effect (FAS/FAE) or mental health disorders concurrent with the harmful use of substances and dependence.

RECOMMENDATION 19

The Committee recommends that a renewed Canada's Drug Strategy include "substitution treatment" such as methadone maintenance as part of a comprehensive approach to the treatment of opiate addiction that includes primary health care, counselling, education and other social services.

RECOMMENDATION 20

The Committee recommends that the proposed clinical trials pilot project in Vancouver, Toronto and Montreal to test the effectiveness of heroin-assisted treatment for drug-dependent individuals resistant to other forms of treatment be implemented and that these trials incorporate protocols for rigorous scientific assessment and evaluation.

RECOMMENDATION 21

The Committee recommends the removal of federal regulatory or legislative barriers to the implementation of scientific trials and pilot projects to determine the effectiveness of new and innovative methods in the treatment of individuals who have developed a pattern of harmful use of substances and dependence.

3. HARM REDUCTION

> *From the merchant who wants to run a business, to the seniors' group who want safe streets, to the provincial government trying to balance health budgets, to the political activists who demand social justice, to the police who want to reduce crime, to the street-involved person who has just witnessed a friend's overdose, the status quo is not an option. It must be made clear to all groups who are impacted by drug use that a harm-reduction approach in no way promotes or legitimizes the use of drugs but rather is a rational approach that will benefit us all.*[183]

Canada's Drug Strategy's stated goal is "to reduce the harm associated with alcohol and other drugs to individuals, families, and communities."[184] A harm reduction approach to the treatment and management of the harmful use of substances gained popularity during the 1980's, when the spread of HIV/AIDS came to be viewed as a greater threat to individuals and public health than the use of substances. Although initially directed toward injection drug use, many jurisdictions have since adapted the harm reduction model to other illicit substances, as well as licit substances like alcohol and tobacco. According to Canada's Drug Strategy, harm reduction is a "realistic, pragmatic, and humane approach" to substance abuse, "as opposed to attempting solely to reduce the use of drugs."[185]

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[183] Dr. Mark Tyndall, Testimony before the Committee, December 3, 2001.

[184] Government of Canada, *Canada's Drug Strategy*, Health Canada, 1998, p. 4.

[185] Ibid.

> *Harm reduction does not provide clear-cut answers and quick solutions, but it has the capacity, if properly applied, to address difficult problems while not compromising the quality and integrity of human life in all its rich and diverse complexity.*[186]

(a) Issues Related to the Definition of Harm Reduction

Evidence before the Committee clearly established that the definition of harm reduction is subject to debate and controversy. Some witnesses recognized that harm reduction is commonly misunderstood and often perceived as encouraging drug use, whereas most would agree that it is part of a continuum of care that can include the long-term goal of abstinence. The Committee believes it is unproductive to suggest a dichotomy between harm reduction and an abstinence-based treatment model, as both are essential to address the harmful use of substances and dependence.

> *The notion of harm reduction is that if people are going to use drugs, we may not like it and we may not approve of it, but let's try to keep them alive and as healthy as possible, and not see them get HIV and hepatitis C, so they can move into rehab programs and treatment programs and other sorts of programs.*[187]

(b) Reducing the Harm Associated with Injection Drug Use

The scope of the problem of injection drug use and its consequential health effects were the subject of a recent Federal/Provincial/Territorial (FPT) Advisory Committee report entitled *Reducing the Harm Associated with Injection Drug Use in Canada.*[188] Information regarding rates and patterns of injection drug use is extremely limited. While there are no precise figures available, it is estimated there are approximately 12,000 injection drug users currently living in Montreal. As well, some studies suggest there are several thousand young people aged 13 to 25 living on the streets of Montreal and approximately half of them have previously injected drugs, while an estimated 8% of those young people begin using drugs intravenously every year.[189] Other estimates suggest that approximately 10,000 to 15,000 injection drug users are living in Toronto. As for the number of injection drug users living in Vancouver's Downtown Eastside, it was estimated at 4,700 in 2000, and the number in the Greater Vancouver region was estimated at 12,000.[190] The Committee acknowledges that there is a significant degree of uncertainty surrounding the number of injection drug users in Canada as it is well known that surveys tend to under-represent marginalized populations such as those who are living on the streets, without telephones, hospitalized or in treatment facilities. However, the numbers above are the most recent estimates made available to the Committee.

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[186] Diane Riley, *The Harm Reduction Model: Pragmatic Approaches to Drug Use from the Area between Intolerance and Neglect*, Canadian Centre on Substance Abuse, 1994, p. 15.

[187] Donald MacPherson, Drug Policy Coordinator, Social Planning Department, City of Vancouver, Testimony before the Committee, December 4, 2001.

[188] *Reducing the Harm Associated With Injection Drug Use in Canada*, Prepared by: FPT Advisory Committee on Population Health, FPT Committee on Alcohol and Other Drug Issues, FPT Advisory Committee on AIDS, FPT Heads of Corrections Working Group on HIV/AIDS, September 2001, available online www.hc-sc.gc.ca/hecs-sesc/cds/publications/injection_drug/toc.htm.

[189] Dr. Carole Morissette, Community Health Specialist, Testimony before the Committee, June 13, 2002.

The FPT Advisory Committee report confirmed that injection drug use is a major risk factor for HIV/AIDS and hepatitis infections, carrying potentially disastrous consequences not only for infected individuals, but also their communities and Canadian society as a whole. Health Canada reported that 24.6% of all new reported positive HIV tests among adults and 14.4% of all reported adult AIDS cases were related to injection drug use in 2001.[191] Aboriginal people are at higher risk than the average citizen of being infected with HIV, as they are over-represented in the sex trade, prison population and among inner-city injection drug use communities.[192] Injection drug use is also a problem among inmates in correctional institutions.[193] Other high-risk populations include women, street youth, sexually exploited children, men who have sex with men, and sex trade workers.

Among other recommendations, the FPT Advisory Committee report called for harm reduction measures such as the expansion of needle exchange programs and increased access to treatment options including methadone maintenance. The report also advocated clinical trials of prescription heroin and urged consideration of a pilot or research project involving a "supervised injection site."

(c) Harm Reduction Measures

Harm reduction measures or strategies have become an integral part of the way many public health and addiction agencies deliver services across Canada. Many service providers see harm reduction as part of a continuum of addiction interventions that include education, prevention, treatment and rehabilitation programs.

Examples of harm reduction measures and policies include:

- Needle exchange programs (NEPs);

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[190] M.T. Schechter, and M.V. O'Shaughnessy, "Distribution of injection drug users in the Lower Mainland," *BC Medical Journal*, Volume 42, Number 2, March 2000.

[191] Health Canada, *HIV and AIDS in Canada: Surveillance Report to 31 December 2001*, Health Canada, 2002, p. 4-6, available online at www.hc-sc.gc.ca/pphb-dgspsp/publicat/aids-sida/haic-vsac1201/index.html.

[192] Glenn Betteridge, Member, Canadian HIV-AIDS Legal Network, *Speaking Notes*, Testimony before the Committee, February 19, 2002.

[193] Injection drug use in prisons is discussed in Chapter 6.

- Methadone maintenance programs and heroin prescription (considered by most practitioners as a form of harm reduction and by many as a form of treatment);[194]

- Education and community-outreach programs;

- Safe injection facilities;

- Sex education;

- Prevention programs such as designated-driver programs aimed at preventing accidents due to impaired driving;

- Server training and intervention against selling alcohol to the already intoxicated or the underaged;

- Policies controlling smoking in public places; and

- Nicotine replacement therapies.

Basically, there are three main ways in which these measures can have an impact on public health:

- By preventing non-fatal and fatal overdoses;

- By preventing the spread of blood-borne diseases and other health problems or injuries associated with alcohol, tobacco and substance use, and risky sexual behaviour; and

- By acting as a gateway to education, prevention, treatment and rehabilitation.

(i) Needle Exchange Programs (NEPs)

The first needle exchange program in Canada was established in Vancouver in 1989. There are no definite data as to the number of NEPs currently in Canada. Estimates range from 100 to approximately 200 programs across the country. Some programs only offer an exchange service where used needles are exchanged for clean ones. Other programs offer a range of public health services including health and addiction assessments, counselling, primary health care, and testing for blood-borne diseases and other illnesses related to injection drug use, as well as referrals to treatment and rehabilitation programs. The Committee observed that there is no consistency in the procedure for the provision of needles and public health services. For example, some

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[194] Methadone maintenance treatment and heroin prescription are discussed in the previous section on treatment.

NEPs provide a "one-for-one" service where a clean needle is exchange for a used needle, while other NEPs do not require users to exchange any needles and will provide any amount of needles requested.

Currently, the federal government is not involved directly in funding needle exchange programs. Some portion of federal transfer payments to the provinces and territories for health expenditures may ultimately support NEPs but it is impossible to determine in what proportion as transfer payments are not designated for specific use. These programs are the responsibility of provincial, territorial and municipal governments. For example, in Ontario, the *Mandatory Health Programs and Services Guidelines* mandate boards of health to "ensure that injection drug users can have access to sterile injection equipment by the provision of needle and syringe exchange programs as a harm reduction strategy to prevent transmission of HIV, hepatitis B, hepatitis C and other blood-borne infections and associated diseases in areas where drug use is recognized as a problem in the community."[195] A majority of Committee members encourage all provinces and territories to adopt similar guidelines to ensure that needle exchange programs are available throughout Canada.

Research on needle exchange programs has demonstrated that some of these programs:

- increase the number of substance-dependent individuals who obtain access to treatment and rehabilitation programs;
- distribute HIV/AIDS risk reduction information and materials;
- provide referrals for testing for blood-borne diseases and counselling;
- reduce needle-sharing;
- reduce the number of contaminated syringes in circulation by providing "sharps containers" for injection drug users to dispose safely of their used needles;
- increase availability and use of sterile equipment thereby reducing the spread of blood-borne diseases;
- do not increase the number of injection drug users or lower the age of first injection; and
- do not increase the number of needles discarded in the community.

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[195] Ministry of Health/Public Health Branch Ontario, *Mandatory Health Programs and Services Guidelines*, December 1997.

Many witnesses appearing before the Committee see community-based outreach programs such as needle exchange programs as an effective way of contacting substance users in their local communities to provide them not only with means to modify risky behaviours related to substance use, but also to modify other risky behaviours such as sex-related unsafe activities. Registered nurses and outreach workers distribute health information, sterile equipment, condoms, pregnancy test kits, vitamins and referrals for drug treatment, HIV, HBV (Hepatitis B) and HCV (Hepatitis C) testing and counselling. Low-threshold services offer substance users who have neglected their health for a long time, a renewed contact with healthcare services and professionals, which, for some injection drug users, may also be a first step to recovery.

> *As I was saying before, I used the needle exchange, and thank God for the needle exchange, because now I'm a mother and I don't have a death sentence over my head, but I think that anything that's not geared toward abstinence is a waste of time. You have to get off the drugs. If you're not geared towards that, then it's useless.*[196]

Many witnesses appearing before the Committee indicated that Canada is facing a severe public health crisis related to injection drug use. Some witnesses argued that the number of Needle Exchange Programs (NEPs) in Canada is insufficient and that their current location (centralized within large cities) is inadequate to respond to the needs of injection drug users.

> *The existing services are clearly insufficient to address all these problems. For example, in the area of transmissible disease prevention, there are five community needle exchange programs in Montreal and approximately 25 other community and institutional partners offering the same service. There are also seven CLSCs and 150 pharmacies that sell syringes without prescription. Nevertheless, at the present time, approximately one million syringes are distributed or sold in Montreal every year. Although that figure has risen since 1995, it remains suboptimal and represents only 10% of estimated needs.*[197]

Other witnesses appearing before the Committee expressed concerns with regard to NEPs as they perceive these programs as "giving up the fight" on substance use and believe they enable a drug-dependent person to continue using or that they may even encourage experimentation with injection drug use. The possibility that more dirty needles would be discarded on the streets and parks was another preoccupation for a number of witnesses.

A majority of Committee members believe that Needle Exchange Programs, when integrated with the delivery of other health care services, contribute to the prevention of the spread of HIV/AIDS and other blood-borne pathogens among injection drug users. A majority of Committee members also believe that NEPs are effective in establishing a first contact with a very marginalized population that most likely would not obtain access to healthcare services otherwise.

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[196] Jamie Hamilton, Testimony before the Committee, December 6, 2001.

[197] Dr. Carole Morissette, Community Health Specialist, Testimony before the Committee, June 13, 2002.

(ii) Safe Injection Facilities

Safe injection facilities or consumption rooms, currently established in some European countries, are controlled healthcare settings where substance users can inject their own drugs using sterile equipment under the supervision of medically trained personnel. The personnel of such facilities can also refer substance users to counselling, healthcare agencies, treatment and rehabilitation programs, and can, in some cases, provide primary health care on the premises. Some European studies conducted in Switzerland and Germany indicate that safe injections facilities:

- prevent overdose deaths;
- have an impact on the overall health of drug users;
- increase the number of drug users in detoxification centres, and abstinence-based and methadone maintenance treatment;
- reduce public nuisance associated with open drug scenes; and
- successfully engage the most marginalized and at-risk substance-dependent individuals.

For example, in Germany, a government report indicates that it is noticeable that in those cities where drug consumption rooms are offered in addition to low-threshold contact services, the mortality rate among drug users has either fallen further, in contrast to the national trend, or else has stabilized at a low level.[198]

There have been few thorough impact evaluation studies of safe injection facilities conducted in Europe, and the majority of the published literature does not currently appear in English.[199] However, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has undertaken a review of available evidence from evaluation studies on consumption rooms in Europe and Australia and a summary of findings will be published by the end of the year 2002.

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[198] This information is taken from the *Addiction and Drug Report 2000* written on behalf of the German Federal Ministry for Health.

[199] Kate Dolan et al., "Drug consumption facilities in Europe and the establishment of supervised injecting centres in Australia," *Drug and Alcohol Review*, vol. 19, 2000, p. 337-346

The Canadian HIV/AIDS Legal Network studied the legal and ethical issues related to the establishment of safe injection facilities in Canada and concluded:

> *Including safe injection facilities as one harm-reduction component of a broader policy response to injection drug use is likely to produce significant benefits for both drug users and the general community.*[200]

The Committee was told that a proposal for the implementation of an 18-month pilot project of two safe injection facilities in Vancouver is currently under study. Some argue that a safe injection facility could reduce risks associated with drug-induced overdoses and resolve some of the public health issues that have plagued, particularly, the Downtown Eastside of Vancouver.[201] The Office of the Chief Coroner of British Columbia determined that in 1998, there were 417 illicit drug deaths in that province. This number has decreased to 222 in 2001 (preliminary data), which is nonetheless an excessively high number of deaths considering that many overdose deaths could be prevented with better information on the purity of heroin on the market and with the implementation of harm reduction measures such as a safe injection site.

An on-going study of the injection drug users in Vancouver (VIDUS)[202] found "that 28% of users shared a needle; 75% of users reported injecting alone at least once; 10% experienced a non-fatal overdose; 14% of users reported injecting in a public place; 25% of addicts reported needing help injecting; and 18% found it hard to access sterile needles."[203] The establishment of supervised safe injection facilities may alleviate these risk-taking behaviours.[204] Furthermore, safe injection facilities may also reduce the downstream health effects of such behaviours seen in high rates of emergency department visits and hospital admissions for soft-tissue infections, overdose, intoxication and withdrawal syndromes.[205] While the scope of the open drug scene in the Downtown Eastside is unparalleled in Canada, no municipality is immune from such a public health and safety crisis. Montreal, Toronto and Ottawa also face significant public health problems related to injection drug use, while other urban and rural communities are seeing more and more problems.

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[200] R. Elliot, *Establishing Safe Injection Facilities in Canada: Legal and Ethical Issues*, Canadian HIV/AIDS Legal Network, 2002, available online at www.aidslaw.ca/Maincontent/issues/druglaws/safeinjection facilities/toc.htm.

[201] *Safe Injection Facilities: Proposal for a Vancouver Pilot Project*, prepared by Thomas Kerr for the Harm Reduction Action Society, November 2000.

[202] The Vancouver Injection Drug Users Study (VIDUS) is a multi-year study of a cohort of over 1,400 injection drug users that began in 1996. The study provides a means of tracking the HIV incidence and prevalence among injection drug users over time. It has reported 100 new HIV infections and 125 deaths among this cohort between its inception in 1996 and the year 2000. Other results of this on-going study have led to numerous publications, the citations of which can be found online through PubMed at www.ncbi.nlm.nih.gov/entrez/queri.fcgi?db=PubMed.

[203] Naomi Brunemeyer, Director of Communications, B.C. Persons With AIDS Society, Testimony before the Committee, December 5, 2001.

[204] E. Wood et al., "Unsafe injection practices in a cohort of injection drug users in Vancouver: could safe injecting rooms help?," *Canadian Medical Association Journal*, August 21, 2001, Volume165, Issue 4, p. 436-7. The content of this CMAJ issue is available online at www.cmaj.ca/content/vol165/Issue4/index.shtml.

[205] Dr. Anita Palepu et al., "Hospital utilization and costs in a cohort of injection drug users", *Canadian Medical Association Journal*, August 21, 2001, Volume 165, Issue 4, p. 415-20.

Some witnesses appearing before the Committee suggested that, in the absence of safe injection facilities and other low-threshold harm-reduction-based services, some injection drug users would continue to engage in dangerous, unhygienic methods of injection that increase the risk of fatal and non-fatal overdoses and of contracting blood-borne diseases such as HIV/AIDS and Hepatitis C. They pointed out that such negative consequences carry a very high cost to the individuals and society as a whole.

> *The final thing I want to say is that within the context of HIV there's something that people often forget. HIV causes AIDS. If you don't get HIV, you do not get AIDS. Therefore, every time you prevent a case of HIV infection, you absolutely prevent a case of AIDS. Unlike other illnesses, we have a disease that is essentially 100% preventable, and that's AIDS. Every time we prevent a case of HIV infection, we save $200,000 of downstream medical care costs. Each year in Canada about 4,000 people are becoming infected with HIV, half of whom are injection drug users. So the mortgage on our children at the present time for HIV is $800 million per year, $400 million of which is for injection drug users who have HIV infection. Therefore, if not for sound social policy but for economic policy, it's absolutely critical that we try to prevent every single case of HIV infection, because the benefits economically and socially are enormous.*[206]

Although most witnesses acknowledged the enormity of the problem, the Committee observed a general ambivalence with the idea of establishing safe injection facilities. Many witnesses were not completely opposed to the idea, but felt there is a need for more research before Canada endorses such an option. Others approved the establishment of safe injection facilities under very specific conditions (e.g., as a measure of last resort for severely addicted individuals; in specific locations; combined with health and treatment services; rigorous monitoring and evaluation; very tight and very controlled criteria of admission; etc.). However, a number of witnesses argued that establishing safe injection facilities endorses substance use and sends a message that can hinder prevention activities. Furthermore, some witnesses were concerned that these facilities could result in public nuisance and increased criminal activity in the communities where they would be established. Others disagreed, stating such fears are unfounded and contrary to existing evidence from European countries where safe injection facilities have been established.[207]

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[206] Dr. Martin Schechter, Head of Epidemiology and Biostatistics, University of British Columbia, Testimony before the Committee, December 3, 2001.

[207] Among others, see the testimony of Warren O'Briain, Director, Community Development, AIDS Vancouver, before the Committee, December 5, 2001.

The Committee has seen directly the public health disaster unfolding in Vancouver. Recognizing that the effectiveness of safe injection sites remains to be demonstrated, a majority of Committee members support the development of more innovative measures to alleviate the very significant health and social problems related to injection drug use.

A majority of Committee members also agree that experimental trials that include protocols for rigorous scientific assessment and evaluation are required to determine whether the establishment of safe injection facilities would significantly reduce the social and health problems currently evident in some drug-affected neighbourhoods. The trials should adopt an integrated public health model that would include the delivery of comprehensive health and social services.

(d) Program Evaluation

Finally, the Committee observed that very few agencies involved in the delivery of harm reduction programs and measures, as well as those involved in the delivery of prevention, education, treatment or rehabilitation services, could provide the Committee with information on the effectiveness and efficiency of their programs based on rigorous evaluations. The Committee believes that a public health approach to the delivery of services in the field of addictions must be evidence-based to achieve its goal of reducing harm related to the use of substances, and dependence.

3.1 COMMITTEE OBSERVATIONS — HARM REDUCTION

The Committee observed the following:

√ *All information points to substance use as primarily a public health issue to be addressed with appropriate public health measures.*

√ *Everything possible must be done to improve the health of substance users and to keep them healthy enough to be able to seek treatment when they are ready.*

√ *Having considered the evidence from witnesses on both sides of the "safe injection site" debate as well as the results of some European studies, it is vital to implement the Canadian pilot project for safe injection facilities, including clear protocols and evaluation components.*

√ *Health Canada needs to play an active role in facilitating, supporting and evaluating the establishment of safe injection sites.*

√ *All programs and services addressing the effects of the harmful use of substances, and dependence, on individuals, families and communities, must include clear guidelines and measurable outcomes that make it* *possible to complete thorough evaluations. Evaluations are necessary to determine the effectiveness of these programs and services, and to ensure that investments are wisely made.*

RECOMMENDATION 22

The Committee recommends that the Government of Canada encourage and assist the provincial, regional and municipal authorities to integrate and deliver needle exchange programs through a public health care model including primary health care services as well as prevention and education, counselling, treatment and rehabilitation programs.

RECOMMENDATION 23

With regard to safe injection facilities, the Committee recommends that the Government of Canada remove any federal regulatory or legislative barriers to the implementation of scientific trials and pilot projects, and assist and encourage the development of protocols to determine the effectiveness of safe injection facilities in reducing the social and health problems related to injection drug use.

RECOMMENDATION 24

The Committee recommends that clear quantitative and qualitative goals be incorporated into all services related to the harmful use of substances, and dependence, together with a performance evaluation process to ensure that prevention, education, treatment, rehabilitation and harm reduction programs are evidence-based and reflect best practices.

RECOMMENDATION 25

The Committee recommends that Canada's Drug Strategy identify harm reduction as a core component of Canadian drug policy that supports interventions to maintain the health of individuals and minimize the public health risks associated with substance use.

4. MISUSE OF PRESCRIPTION DRUGS

It is important at the outset to distinguish between individuals who misuse prescribed drugs to the detriment of their own health and those who abuse the health care system to obtain specific drugs that they sell for profit.

The Committee was told that a lack of education and, hence, awareness among physicians, pharmacists and the general public about the risks of misusing certain drugs, or of developing a dependence on certain medications, may contribute to prescription drug misuse. Witnesses appearing before the Committee argued that physicians generally receive inadequate training on how to manage pain for patients, on how to detect problems associated with the harmful use of substances, and on how to treat those individuals who may be at risk of developing a dependence on substances. Similarly, the Committee was told that patients may misuse prescription drugs simply because they are not given sufficient information about the medications they are prescribed and the way they should be used.

> *In Canada, we have had successful campaigns highlighting the dangers of smoking and alcohol consumption. We would recommend the development of a national campaign to explain the possible dangers of abuse and misuse of prescription drugs. Prescription drugs are now the medical intervention of choice, and usually for good reason, as they provide tremendous health benefits. People are under the impression that prescription drugs have no ill effects and can do no harm. A campaign should sensitize Canadians to the fact that while a drug is prescribed for a good reason, some drugs can lead to dependence and addiction and do not achieve their goals if taken improperly. The campaign should also provide people with information on what to look out for and whom they should be consulting when questions arise about their medications.*[208]

The Committee agrees that there is a need to deliver better education and awareness programs to patients, physicians and other health care professionals about the risk of developing a dependence on certain prescription drugs. The Committee believes the risks of prescription drug misuse should be included in a national mass media public awareness campaign addressing the non-medical use of drugs and other substances as recommended earlier in this chapter.

Another important issue related to the misuse of prescription drugs is that of the diversion of such drugs from legitimate markets. Codeine, Dilaudid, OxyContin, Talwin, Ritalin and Percocet are among the most common prescription drugs being misused and diverted in this way. Users ingest these drugs orally or crush the tablets and either snort the substance or dissolve it for injection. OxyContin has recently attracted much attention in the United States, but, thus far, has not been identified as a major problem in Canada. However, the profits to be made on the sale of OxyContin and other analgesics and stimulants on the illegal market are huge and attractive to those who misuse these prescription drugs, as well as to criminal organizations. For example, the Committee was told, "sixty 40 milligram OxyContin tablets retail for $300 US, but the same drugs would attract $2,400 on the street."[209] The manufacturer of OxyContin has recognized the problems associated with the diversion of this drug and "is currently developing a new product that will contain beads of the anti-opiate Naltrexol, which apparently will make the drug less rewarding for the addict".[210]

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[208] Dr. Barry Power, PharmaD, Director of Practice Development, Canadian Pharmacists Association, Testimony before the Committee, August 27, 2002.

[209] Dr. Brian Taylor, Deputy Registrar, College of Physicians and Surgeons of British Columbia, Testimony before the Committee, August 28, 2002.

According to a number of submissions to the Committee, prescription drug misuse is prevalent, to a greater or lesser extent, in most communities across Canada. Anecdotal evidence suggests that the illicit trade in certain prescription drugs is more prevalent in some smaller cities and rural areas where, coincidentally or not, heroin and cocaine are not widely available. Many factors contribute to or facilitate the diversion of prescription drugs. While they may be stolen from various points in the legitimate distribution system, some witnesses appearing before the Committee said that the vast majority of prescribed drugs come from legal prescriptions obtained through "double-doctoring" or "multi-doctoring":

> *In the past, when the RCMP have done investigations and apprehended certain information under search warrants, we have seen maps drawn by people who are going to go double-doctoring. They time their visits so they may visit 10 clinics in a day. Given the waiting time in some family physicians' offices, you might wonder how that's possible, but they know walk-in-clinics and other clinics are likely to give them quick access. They can literally hit 10 doctors in a day with a very sophisticated story of having lost their drugs, flushed them down the toilet, the dog eating them, or whatever, and they do get an enormous amount of a drug.*[211]

Prescription monitoring programs have the potential to limit the growth of prescription drug misuse, reduce fraud and prevent the diversion of prescribed drugs. Although 10 of 12 provinces and territories apparently had triplicate prescription programs in place in 1997, the Committee was told that unless the information is readily obtainable from a central database, incidents of double-doctoring or inappropriate prescribing might not be discovered early enough to allow for a successful intervention. To prevent fraud and detect potential substance misuse problems, pharmacists and physicians need immediate access to a patient's drug profile at the time a medication is being prescribed or dispensed.

The Committee heard from representatives of various prescription monitoring programs from British Columbia, Nova Scotia and Saskatchewan. All agreed that the B.C. PharmaNet program, introduced by the province of British Columbia in 1995, is the most promising monitoring program currently available in Canada. The program relies on an electronic central database that gives physicians and pharmacists an easy access to up-to-date data on medications dispensed to a patient living in that province.

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[210] Ibid.

[211] Dr. Dennis Kendel, Registrar, College of Physicians and Surgeons of Saskatchewan, Testimony before the Committee, August 28, 2002.

> *The PharmaNet program, as you may well know already, is a joint venture of the Ministry of Health's pharmacare, the College of Physicians and Surgeons, and the College of Pharmacists of our province. All prescriptions are electronically captured at the time they are dispensed so the data are very current: we can see what the patient received earlier today.*
>
> *[...]*
>
> *The whole of the PharmaNet program has been reviewed by the Privacy Commissioner and has been approved. I think the PharmaNet program might be something to be considered across Canada as a means of addressing some of the problems with the diversion of prescribed drugs.*[212]

The PharmaNet database is currently being used in all emergency departments in British Columbia on a pilot project basis. The BC College of Physicians and Surgeons is hoping that in the near future all physicians in private practice will have access to PharmaNet in their offices. This initiative is a first in Canada where a medical practitioner can request and access up-to-date records of medications dispensed to a patient by the secure transmission of information over the Internet. The program is not a "watchdog" but a proactive system, supported by the physicians of British Columbia, which provides them with valuable information on a patient's drug profile and may help to avoid dangerous medication interactions and duplications. In addition, it has the benefit of limiting prescription fraud and serves as an early warning system of a potential substance misuse problem.[213] The program also offers physicians the resources of an advisory committee of clinical pharmacologists, which can offer them advice when faced with problem patients.[214]

The Committee applauds the initiatives put in place to monitor prescribed drugs by colleges of physicians and surgeons across the country. The Committee also recognizes that prescription monitoring programs vary substantially from one province to another. The Committee, in agreement with a number of witnesses appearing before it, sees real benefits in the use of real-time electronic databases in monitoring prescribed drugs most commonly subject to misuse and diversion, and in providing health care professionals with access to reliable up-to-date data to make better informed decisions on a course of treatment.

The Committee was also told that the fairly recent phenomenon of Internet prescribing is a source of concern. It is virtually impossible to monitor the drugs being prescribed and dispensed using the Internet, as a patient using such a service can acquire medications and easily bypass any prescription monitoring program currently in place. The Committee believes Internet prescribing raises many complex legal and ethical issues that should be investigated closely to determine what, if any, intervention is necessary.

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[212] Dr. Brian Taylor, Deputy Registrar, College of Physicians and Surgeons of British Columbia, Testimony before the Committee, August 28, 2002.

[213] More information on PharmaNet is available on the Ministry of Health Services Web site at healthnet.hnet.bc.ca/catalogu/products/pnet/.

[214] Dr. Brian Taylor, Deputy Registrar, College of Physicians and Surgeons of British Columbia, Testimony before the Committee, August 28, 2002.

Finally, some concerns were raised over the misuse of over-the-counter drugs (e.g., drugs containing Dextromethorphan, antihistamine, codeine etc.). Unfortunately, there is virtually no Canadian data on this public health issue. The Committee believes that accurate information on the prevalence and incidence of use and harmful use of over-the-counter drugs is needed and should be integrated into a comprehensive drug policy addressing the harmful use of all substances.

4.1 COMMITTEE OBSERVATIONS — MISUSE OF PRESCRIPTION DRUGS

The Committee observed the following:

√ *The system for dispensing prescription drugs in certain jurisdictions does not have the capacity to detect promptly any potential misuse of prescription drugs.*

√ *In an attempt to respond to the problem of the misuse of prescription drugs, an informal exchange of information between pharmacists and physicians is taking place in some regions of Canada. This informal information system raises many concerns with respect to privacy rights. The establishment of real-time electronic databases to monitor prescription drugs, with strict access rules and safeguards to protect the information being transmitted, would offer better protection for the privacy rights of Canadians.*

RECOMMENDATION 26

The Committee recommends that a renewed Canada's Drug Strategy include in its priorities the development of a strategy relating specifically to the misuse of over-the-counter and prescription drugs in Canada.

RECOMMENDATION 27

The Committee recommends that the Government of Canada assist and encourage the provinces and territories in the development and maintenance of comparable real-time databases so as to track better the prescribing and dispensing of commonly misused prescription drugs.

CHAPTER 6: SUBSTANCE USE AND PUBLIC SAFETY

According to the federal government's own policy statement, "Canada's Drug Strategy reflects a balance between reducing the supply of drugs and reducing the demand for drugs."[215] In furtherance of Parliament's criminal law powers under the Constitution, as well as in the discharge of its responsibilities in the areas of border control and penitentiaries, the federal government devotes more than $400 million annually to reducing the supply of illicit substances.[216] The most important of the federal legislative controls are exercised through the *Controlled Drugs and Substances Act,* (CDSA)[217] which prohibits the production, trafficking and possession of a host of psychotropic substances and provides penalties specific to the nature and quantity of the substance in question. Among the many federal entities that play a role in supply reduction, the Royal Canadian Mounted Police (RCMP) are responsible for enforcing the *Controlled Drugs and Substances Act*, with the help and cooperation of provincial and municipal police forces throughout Canada. The Canada Customs and Revenue Agency (CCRA) is mandated to reduce the supply of illicit substances and other contraband through border control measures aimed at intercepting shipments intended for the Canadian market. For its part, Justice Canada is responsible for prosecutions, while Correctional Service Canada administers many substance-related sentences, in addition to conducting urinalysis testing and other security measures aimed at preventing offenders' use of illicit substances and other contraband.

This Chapter will review those public safety responsibilities and initiatives that together constitute a major portion of the federal government's contribution toward the implementation of Canada's Drug Strategy.

1. THE *CONTROLLED DRUGS AND SUBSTANCES ACT*

Psychotropic substances were not regulated in Canada until 1908, when the importation, manufacture, sale, and possession for sale of opium were first prohibited. In 1911, the *Opium and Drug Act* was broadened to prohibit transportation and possession and to extend the law to cover morphine and cocaine. In 1923, the legislation, by then called the *Opium and Narcotic Drug Act*, was amended to include cannabis, heroin and codeine. Over time, amendments expanded the list of substances covered as well as the administrative controls placed on their legal manufacture, production, and sale. Finally, in 1961, the *Narcotic Control Act* was adopted, forming the basis for Canada's existing legislative scheme, contained in the *Controlled Drugs and Substances Act* since 1997.[218]

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[215] Government of Canada, *Canada's Drug Strategy*, Health Canada, 1998, p. 1.

[216] Office of the Auditor General of Canada, *2001 Report of the Auditor General of Canada*, Chapter 11 — Illicit Drugs: The Federal Government's Role, 2001.

[217] S.C. 1996, c. 19.

(a) Criminal Offences and Penalties

The *Controlled Drugs and Substances Act* (CDSA) repealed and replaced the *Narcotic Control Act* and Parts III and IV of the *Food and Drugs Act*. The offences and penalties are set out in Part I of the Act. Offences include the production (cultivation or manufacture), importation, exportation, possession, trafficking, and possession for the purposes (of exportation or trafficking) of a long list of psychoactive substances. Those substances are set out in Schedules to the Act and the range of penalties available for a given offence is determined by the Schedule in which the substance appears and/or the number of prior convictions. For example, possession of heroin or cocaine (Schedule I) is a hybrid offence punishable by up to seven years imprisonment where the Crown proceeds by indictment. When prosecuted as a summary conviction offence, the maximum available penalty for a first offence is a $1,000 fine or six months in jail, or both, while subsequent offences may draw a fine of up to $2,000 and/or a year in jail. Possession of amphetamines (Schedule III) is punishable by up to three years imprisonment, where the Crown proceeds by indictment, while the maximum summary conviction penalties are the same as for Schedule I drugs. Cannabis products are found in Schedules II, VII, and VIII and maximum penalties for both possession and trafficking will depend upon the amount involved.[219] Laws respecting cannabis are discussed in greater detail in Chapter 9.

The *Controlled Drugs and Substances Act* also prohibits seeking or obtaining Scheduled substances or prescriptions for Scheduled substances, without disclosing substances or prescriptions that were obtained during the previous 30 days (so-called "double-doctoring").[220] Section 8 of the Act makes it an offence to possess any property obtained as a result of a Part I offence and section 9 prohibits the "laundering" of any such proceeds. Depending upon the value of the property involved, the maximum penalty for either offence can be up to ten years in prison when prosecuted by indictment. Section 10(1) expands upon the purpose of sentencing as set out in section 718 of the *Criminal Code*, by referring to the need to encourage rehabilitation and treatment of offenders "in appropriate circumstances." Section 10(2) includes a list of aggravating factors to be considered in sentencing such as a prior conviction, the use or threatened use of a weapon or violence, and offences committed in or near schools or involving persons under the age of eighteen. Part II of the Act contains the search, seizure and detention provisions that enable enforcement.[221] Part II also authorizes the courts to order the restraint and/or forfeiture of offence-related property, as well as the forfeiture of proceeds of crime, while Part III of the Act governs the disposal of controlled substances.

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[218] Paul St-Denis, Senior Counsel, Criminal Law Policy Section, Department of Justice, Testimony before the Committee, October 1, 2001.

[219] S.C. 1996, c. 19, sections 4(4) and (5) and 5(3) and (4). For example, possession of not more than 30 grams of cannabis or 1 gram of cannabis resin is a purely summary conviction offence with a maximum penalty of $1,000 fine or six months in jail or both.

[220] S.C. 1996, c.19, section 4(2). "Double doctoring" is discussed in detail in Chapter 5 of this report, under the heading "Misuse of Prescription Drugs."

(b) Regulatory Compliance

Because many of the substances listed in the CDSA Schedules have a legitimate medical purpose, the offences under the Act are drafted in such a way as to exempt criminal liability through Regulation. For example, Section 4 prohibits possession of a substance included in Schedules I to III, "except as authorized under the regulations." Similarly, Section 2 defines "traffic" as selling, transporting, delivering, etc., a substance included in any of Schedules I to IV, "otherwise than under the authority of the regulations." The Act contains similar exemptions for importing, exporting, or producing substances listed under specified Schedules.[222] Exemptions are administered under Part IV of the Act, which also authorizes the appointment of inspectors with powers to ensure compliance with the regulations. For example, inspectors can enter into any place "used for the purpose of conducting the business or professional practice of any person licensed or otherwise authorized under the regulations to deal in a controlled substance or a precursor."[223]

Part V of the Act gives the Minister of Health the power to suspend, cancel or amend a licence, permit or authorization, in the event that a "designated" regulation is believed to have been contravened in a manner that poses "substantial risk of immediate danger to the health or safety of any person."[224] The Minister's finding of a contravention is subject to review by an adjudicator, whose decision will determine whether the interim order may be affirmed, altered, or revoked by the Minister, or cease to have effect. Part VI contains provisions relating to the analysis of substances, the appointment of analysts, and the use of analysts' certificates in criminal prosecutions. Part VI also gives the Governor in Council broad powers under Section 55 to make regulations relating to "the medical, scientific and industrial applications and distribution of controlled substances and precursors," as well as the enforcement of the Act. Finally, Section 56 gives the Minister of Health the power to exempt persons or substances from the provisions of the act where "necessary for a medical or scientific purpose" or otherwise in the public interest.[225]

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[221] Section 11 authorizes the issuance of a search warrant and the seizure of controlled substances, as well as offence-related property, while Section 13 incorporates *Criminal Code* provisions governing the detention of items seized.

[222] S.C. 1996, c. 19, Sections 6(1) and 7 (1).

[223] S.C. 1996, c. 19, Section 31(1).

[224] S.C. 1996, c. 19, Section 35.

[225] It is under the authority of this section that the Minister of Health is empowered to issue exemptions from the prohibitions concerning marijuana, for the purposes of medical treatment.

2. ALTERNATIVES TO PROSECUTION AND/OR INCARCERATION

Many witnesses told the Committee that they viewed substance dependence as a health issue. Consequently, they felt that criminal prosecution for behaviour linked to substance dependence was unlikely to have any lasting positive impact. Instead, several witnesses advocated the use of various alternatives to prosecution and/or incarceration to acknowledge and address the underlying dependence, while at the same time hold the offender responsible for his criminal behaviour.

(a) Drug Treatment Courts

One of the more popular alternatives recommended by witnesses was an expanded Drug Treatment Court program. In an approach that began in the United States, drug treatment courts utilize "a blend of judicial supervision, sanctions for non-compliance and incentives for reduced drug use to motivate offenders to successfully complete addiction treatment."[226] The Toronto Drug Treatment Court was established in 1998 and is funded through the Investment Fund of the *National Strategy on Community Safety and Crime Prevention*, administered jointly by the Department of Justice and the Solicitor General of Canada. A December 1998 press release by the Solicitor General described the program as a collaborative effort of the Centre for Addiction and Mental Health, Toronto's criminal justice system, Toronto Police Services, the City of Toronto Public Health Office, and various community-based service agencies. A first of its kind in Canada, goals of this pilot project were "to reduce drug abuse and criminal behaviour through treatment, and demonstrate the cost-effectiveness of a diversion model as an alternative to incarceration."

As part of this study, the Committee was able to observe proceedings of the Toronto Drug Treatment Court and consult with officials, staff and various service-providers associated with the Court. The Toronto program provides court-supervised treatment, through the Centre for Addiction and Mental Health, for offenders who are dependent on cocaine or opiates. Upon successful completion of the program, those with little or no criminal record who are charged with possession of cocaine or heroin can have their charges withdrawn. According to a Program Summary published by the Toronto Drug Treatment Court, non-violent offenders charged with trafficking in small quantities of cocaine or heroin must enter a guilty plea in order to participate, but graduation from the program can result in a non-custodial sentence. A final evaluation of the program is not expected until late 2004. However, the same December 2001 Program Summary cites interim reports showing a reduction in drug use and criminal behaviour among Treatment Court participants, when compared with similar offenders in the traditional court system.

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[226] *Closing the 'Revolving Door': The Toronto Drug Treatment Court*, Caledon Institute of Social Policy, January 2001.

Likewise, while a cost savings analysis has yet to be completed, the Summary points out that it costs an estimated $8,000 annually to provide substance abuse treatment to a program participant, as opposed to $45,000 to incarcerate the same offender for a year.

In September 2001, the Minister of Justice announced the grant of additional funding to support the operation of the Toronto court until December 2004. Since then, a second Drug Treatment Court was launched in Vancouver on December 4, 2001. The Drug Treatment Court of Vancouver is another four-year pilot project with goals and funding sources similar to those of the Toronto program. The Department of Justice has promised "rigorous" evaluations of both the Toronto and Vancouver programs in order to determine their cost-effectiveness, efficiency, and overall success.

The Committee found that support for Drug Treatment Courts is not unanimous. Some witnesses, for example, argued that coerced or mandated treatment is unlikely to be successful, while others saw drug treatment courts as simply a means of widening the net of social controls. Some of those in favour of the courts believe that there are substance-dependent offenders who need a strong external source of motivation before they will seek treatment. Some witnesses expressed conditional support for drug treatment courts, so long as they don't replace or reduce access to voluntary treatment.

The Committee believes that Drug Treatment Courts offer a promising alternative for some substance-dependent offenders, particularly when individuals are linked with necessary social services at the same time as they are given access to treatment for their dependence. In such a context, participation in drug treatment courts should increase the likelihood of successful interventions with this group of offenders. That, in turn, could have far-reaching benefits for society as a whole, in the form of lower health care costs, as well as reduced victimization. In the event that evaluations of existing pilot projects demonstrate that offenders entering and/or completing the program have better outcomes, the Committee believes that comprehensive drug treatment court programs should be a permanent part of the criminal justice system.

(b) Mandated Treatment

In order to ensure more effective intervention and treatment, some have suggested mandatory treatment as a sentencing option for repeat offenders who support their substance dependence through criminal activity. Others adamantly opposed such measures on the ground that coerced treatment simply doesn't work and/or runs counter to important societal values of personal freedom and autonomy. Section 10 of the CDSA points out that the fundamental purpose of sentencing under Part I of the Act includes "encouraging rehabilitation, and treatment" of offenders "in appropriate circumstances." However, it appears that Section 10 would have no application to a sentence imposed for a *Criminal Code* offence, even if its commission was linked to substance dependence. At present, the *Criminal Code* does permit a sentencing judge to order, as a condition of probation, attendance at "a program for curative treatment in relation to the consumption of alcohol or drugs," for the purposes of assessment and treatment as recommended.[227]

It must be noted that Part II of the *Narcotic Control Act* at one time provided for preventive detention and detention for treatment, in provisions that were enacted in 1961 but never proclaimed in force.[228] It is also instructive to consider the misgivings of the Le Dain Commission respecting whether those provisions were "sufficiently related to the issue of criminal responsibility to be a valid criminal law disposition of a case."[229] The Commission expressed doubt "despite the close connection between 'addiction' and crime, that Parliament's power to legislate for the prevention of crime would give it power to provide for compulsory treatment of 'addiction'."[230]

The Committee is aware that the possibility of coerced or mandated treatment of offenders raises important practical and ethical questions. For example, treatment providers may simply refuse to treat those mandated offenders who are unwilling or uninterested in overcoming their dependency. Mandated treatment, as part of a sentence for substance-related crime, would also be manifestly unfair if it came at the expense of voluntary treatment options for persons who are not involved with the criminal justice system. Finally, the Committee acknowledges that imposed or mandated treatment runs a serious risk of offending the *Canadian Charter of Rights and Freedoms*.

Nevertheless, we agree that the courts are in need of more and better options for dealing with repeat offenders whose involvement with the criminal justice system comes as a result of their dependence on illicit substances, particularly where drug treatment courts are not available. For that reason, the Committee would like to see a review of the *Controlled Drugs and Substances Act* and the *Criminal Code*, to determine whether it is possible to provide sentencing courts with more creative alternatives to fines and incarceration, in appropriate cases, that would address more effectively the underlying causes of criminality.

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[227] *Criminal Code*, R.S.C. chap. C 46, Section 732.1 (3) (g.1).

[228] S.C. 1961, c. 35.

[229] *Commission of Inquiry into the Non-Medical Use of Drugs: Final Report*, Information Canada, Ottawa, 1973, p. 1013.

[230] Ibid.

2.1 COMMITTEE OBSERVATIONS — ALTERNATIVES TO PROSECUTION AND/OR INCARCERATION

The Committee observed the following:

√ *In most cases, prosecution and incarceration for criminal behaviour linked to drug dependence does not achieve desired, lasting, positive outcomes.*

√ *Drug Treatment Courts can offer a promising alternative for some substance-dependent offenders, particularly when supervision and treatment are supported by the necessary social services.*

√ *Mandated or coercive treatment options may pose ethical, legal and practical questions.*

√ *Drug Treatment Courts or the use of mandatory treatment must be fully evaluated before additional investment or policy change is undertaken.*

RECOMMENDATION 28

The Committee recommends continued support for existing Drug Treatment Court pilot projects and, if indicated by evaluation outcomes, the Committee further recommends permanent funding of those Courts, with support for additional sites.

RECOMMENDATION 29

The Committee recommends that the Minister of Health and the Minister of Justice propose appropriate amendments to the *Controlled Drugs and Substances Act* and/or the *Criminal Code* to provide a wider range of sentencing options, including treatment, for substance-dependent individuals involved with the criminal justice system.

3. CORRECTIONAL FACILITIES

> *Drug and alcohol abuse is a major concern in federal corrections. Upon admission to federal custody, almost 70% of federal offenders are assessed as having some level of substance abuse problem requiring intervention. According to results obtained on an inmate survey, 34% of offenders admitted to injection drug use*

> *prior to incarceration and 11% indicated they have injected since they have been in custody. Twenty-five percent of inmates reported that they are under pressure to smuggle drugs into the institution.*[231]

As one way of dealing more effectively with the problem of substance use in prisons, Correctional Service Canada (CSC) implemented a pilot program in February 2000 that involved establishment of Intensive Support Units (ISU) within several penitentiaries.

> *The main purpose of the ISU is to provide a safe environment where offenders can live substance-free with enhanced support and intervention of staff. The Units are available to both offenders with substance abuse problems and to individuals without substance abuse problems but who wish to live in an environment that is free of drugs and interpersonal problems associated with offender drug use.*[232]

CSC also offers treatment programs, like Choices for parolees and the Offender Substance Abuse Pre-Release Program (OSAPP), to those offenders who request or need intervention. In order to develop and evaluate treatment programs for federal offenders, CSC opened the Addictions Research Centre in Montague, Prince Edward Island, in May 2001. The Centre conducts its own independent studies, in addition to working with other researchers from federal, provincial and territorial agencies, non-governmental organizations and universities.

The problem of substance use in federal prisons is well documented, as is the evidence of all attendant health consequences. This should come as no surprise, since logic suggests that prisons will share many of the social ills of the population at large, including harmful use, dependence and trafficking in illicit substances. There are at least two different but important aspects of the problem of illicit substances in prisons. One concerns the threat that the illicit trade poses to the security of institutions, including staff and inmates, and the other, the devastating impact of harmful use and dependence on the health of inmates and, ultimately, on their families and society at large.

(a) Security of Institutions

Correctional Service Canada's inability to stop the flow of illicit substances into federal prisons is seen as a major problem. Because federal prisons constitute a highly controlled environment, one might expect that prison authorities would have the advantage in stopping the flow of such contraband into their institutions. However, prisons and inmates are not closed off entirely from the outside world. The day-to-day administration of federal institutions requires the provision of many goods and services by those outside the prison system. Likewise, many staff, inmates, and visitors pass through the doors of federal institutions on any given day.

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[231] F. McVie, "Drugs in federal corrections — The issues and challenges," *Forum on Corrections Research*, September 2001, Volume 13, No. 3, p. 7.

[232] D. Varis, "Intensive support units for federal inmates: A descriptive review," *Forum on Corrections Research*, September 2001, Volume 13, No. 3, p. 41.

The trade in illicit substances in prisons carries the potential for even greater problems than those that may occur outside institutions. Coercion and intimidation may be much more easily exercised in a closed environment where inmates and even visitors may feel they have little choice other than to ignore, if not co-operate with, traffickers. The Committee is aware that CSC takes the interdiction of illicit substances and other contraband very seriously and uses a number of intelligence and surveillance techniques to achieve that end, in collaboration with police agencies in the community. The Service also makes use of special equipment, such as ion scanners, to detect the presence of illicit substances and a drug dog program has been introduced that will eventually cover all CSC sites within the next three years.[233]

While it is tempting to seek a solution to this problem through more intrusive searches and a greater willingness to ban certain visitors, one must bear in mind the legislated policy statements underlying the Service's obligation to foster links between inmates and the community. For example, Section 3(*b*) of the *Corrections and Conditional Release Act*[234] makes clear that the purpose of the CSC is to contribute to a just, peaceful, and safe society by carrying out sentences imposed by the courts while "assisting the rehabilitation of offenders and their reintegration into the community as law-abiding citizens through the provision of programs in penitentiaries and in the community." Furthermore, it is said that those inmates who are able to maintain relationships with family members throughout their period of incarceration stand a better chance of successful reintegration when finally released back into the community. Nevertheless, the Committee believes that CSC must continue to develop new technologies and procedures to curtail more effectively the traffic of illicit substances into and within institutions. For that reason, we believe policies and procedures must be reviewed on a regular basis.

(b) Health of Offenders

The health risks associated with injection drug use (IDU) in prisons are also well documented.

> *In Canada's federal prison system (where offenders sentenced to prison terms of two years or more serve their terms), the number of reported cases of HIV/AIDS rose from 14 in January 1989 to 159 in March 1996 and 217 in December 2000. This means that 1.66 percent of all federal prison inmates are known to be HIV-positive. ...*

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[233] Ross Toller, Director General, Offender Programs and Reintegration, Correctional Service Canada, Testimony before the Committee, October 3, 2001.

[234] S.C. 1992, c. 20.

> *Hepatitis C (HCV) prevalence rates in prisons are even higher than HIV prevalence rates: studies undertaken in the early and mid 1990s in Canadian prisons revealed rates of between 28 and 40 percent.*[235]

The incidence of HIV among federal inmates is significantly higher than that of the general population. Furthermore, the incidence of Hepatitis C infection has reached epidemic proportions, much the same as it has among injection drug users in the population at large. The reasons behind the high infection rates are varied. For example, some injection drug users who enter prison are already HIV-positive and/or Hepatitis C-positive. Some will continue injecting in prison, where there are no needle exchange programs and where access to methadone substitution may be limited. If infected inmates share contaminated equipment with other injection drug users within the institution, the further spread of blood-borne diseases is a virtual certainty.

A number of proposals were made to the Committee aimed at addressing some of the more obvious health risks involved in injection drug use among inmates. For example, it has been suggested that CSC should eliminate random testing of urine for marijuana because it may encourage marijuana users to move to more harmful substances in order to avoid detection and sanctions (since marijuana is detectable in urine for much longer periods of time). However, CSC staff has disputed that assertion, relying on evidence of "random testing results where 49% of the positive tests continue to demonstrate THC use."[236] There have also been calls to institute needle exchange programs within institutions, since there is good evidence that the availability of clean needles has helped to reduce the spread of blood-borne viruses among injection drug users in the community.[237] Citing security concerns, CSC has thus far provided bleach kits for sterilizing injection equipment, in lieu of establishing needle exchange programs. Finally, although it is possible for federal inmates to continue methadone maintenance treatment, the Committee was told that those not already enrolled in such a program, at the time of their incarceration, are able to access methadone maintenance only under exceptional circumstances.[238] The Committee believes that federal inmates' access to methadone maintenance programs should be based on eligibility criteria similar to those used in the community at large.

Furthermore, while recognizing the unique security challenges encountered in correctional facilities, the Committee believes that Correctional Service Canada must continue to explore more and better ways to protect the health of inmates, staff, and society at large.

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[235] The Canadian HIV/AIDS Legal Network, *HIV/AIDS and Hepatitis C in Prisons: The Facts*, 2001/2002.

[236] F. McVie, "Drugs in federal corrections — The issues and challenges," *Forum on Corrections Research*, September 2001, Volume 13, No. 3, p. 7.

[237] Koshala Nallanayagam, Prisoners with HIV/AIDS Support Action Network, Testimony before the Committee, February 19, 2002.

[238] Canadian HIV/AIDS Legal Network, Brief to the Committee, February 19, 2002, p. 28.

Although some offenders will benefit from the support provided by substitution therapy or other harm-reducing measures, the Committee is aware that there are many others who would prefer to undertake treatment, particularly during their incarceration, that will assist them in adopting a new lifestyle free of alcohol and other substances. For that reason, the Committee believes that abstinence-based treatment programs must continue to be a key component of CSC's response to the use of licit and illicit substances.

As mentioned above, the Committee is aware that CSC has established a pilot project of Intensive Support Units, within a number of institutions, for the benefit of offenders who wish to live in a substance-free environment. A majority of members applaud the innovative thinking behind such measures, even though the Committee was told that it could be difficult to exclude the pressures that may continue to be exerted on ISU inmates from elsewhere in the institution. Therefore, the Committee suggests that CSC explore the concept further by dedicating entire institutions, in both western and eastern regions of Canada, to providing highly motivated offenders with intensive, abstinence-based treatment, in a substance free and secure environment.

As previously mentioned, the Committee heard evidence of the various substance use treatment programs offered to offenders within institutions, as well as those on conditional release. However, in order to increase the likelihood of successful outcomes, the Committee agrees that offenders must be able to access treatment, upon request, without unreasonable or undue delay. To that end, the Committee urges CSC to ensure that a federally incarcerated offender's access to such treatment is not determined by the proximity of his or her parole eligibility date, or delayed until conditional release is imminent.

3.1 COMMITTEE OBSERVATIONS — CORRECTIONAL FACILITIES

The Committee observed the following:

√ *Correctional Service Canada's inability to stop the flow of drugs into prisons is a major problem requiring immediate attention.*

√ *More must be done to address the alarming incidence of substance use among incarcerated offenders, as well as the health risks associated with that use.*

√ *To successfully address substance use, harmful use and dependence among incarcerated offenders, Correctional Service Canada must offer access to a full range of treatment options in a secure and substance-free environment.*

RECOMMENDATION 30

The Committee recommends that Correctional Service Canada be required to develop and implement a three-year plan to reduce substantially the flow of illicit drugs into prisons. The Committee further recommends that the proposed Canadian Drug Commissioner be consulted in setting the goals of the plan and responsible for monitoring results.

RECOMMENDATION 31

The Committee recommends that Correctional Service Canada provide incarcerated offenders with access to substitution therapies, such as methadone, based on eligibility criteria similar to those used in the community at large.

RECOMMENDATION 32

The Committee recommends that Correctional Service Canada allow incarcerated offenders access to harm-reducing interventions, in order to reduce the incidence of blood-borne diseases, in a manner consistent with the security requirements within institutions.

RECOMMENDATION 33

The Committee recommends that Correctional Service Canada continue to promote abstinence as its overriding treatment objective.

RECOMMENDATION 34

The Committee recommends that Correctional Service Canada undertake, as a pilot project, the establishment of two federal correctional facilities reserved for offenders who wish to serve their sentence in a substance-free environment with access to intensive treatment and support.

RECOMMENDATION 35

The Committee urges Correctional Service Canada to ensure that there are sufficient programs and spaces available to allow offenders access to treatment for substance use, as needed, immediately following their incarceration.

4. BORDER CONTROL

The Canada Customs and Revenue Agency (CCRA) is the federal agency responsible for the interception of illicit substances and other contraband at the first point of entry into Canada. The CCRA works in partnership with the RCMP and other domestic police forces, as well as foreign law enforcement agencies like the United States Customs Service, the U.S. Drug Enforcement Agency and INTERPOL.[239]

At the earliest stages of this study, the Committee was briefed by officials of the CCRA on its mandate and activities, with respect to illicit substances. The Committee traveled to border crossings in the Niagara region and met with CCRA staff responsible for their control. Committee members were also received and briefed by Customs officials at Dorval Airport and the Port of Montreal. In addition, local CCRA officials appeared at Committee meetings in Toronto and Vancouver.

Although the CCRA has sophisticated contraband detection equipment, including x-ray machines, ion scanners, fibrescopes and detector dog teams, only a small amount of the illicit substances destined for Canada can be intercepted, given the sheer volume of goods and people crossing the border on any given day. This happens in spite of a highly developed system of co-operation with other enforcement agencies, as well as commercial shipping interests, for the purposes of intelligence gathering and analysis. Although CCRA officials did mention that recent amendments to the law, in the form of Bill S-23,[240] will provide valuable assistance to their interdiction efforts, the point was also made that "the most progress could be made with appropriate funding, appropriate resource allocation that would ensure that interdiction can continue to increase."[241]

The Committee recognizes that the efficient movement of legitimate trade, in and out of Canada, is crucial to the economic health of this country. Obviously, that reality exerts additional pressure on Customs officials to fulfill their interdiction responsibilities in a timely manner, but without compromising the security of our borders. Given those demands and the absolute necessity for effective interdiction, the Committee believes that those activities of the Canada Customs and Revenue Agency must be adequately resourced.

In spite of the resources and expertise employed by the CCRA, the Committee was told that organized crime activities pose a major obstacle to the interdiction of contraband at the Port of Montreal. It seems that part of the blame for this may rest with uncertain or fragmented law enforcement responsibilities, especially since the Ports

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[239] Mark Connolly, Director General, Contraband and Intelligence Services Directorate, Customs Branch, Canada Customs and Revenue Agency, Testimony before the Committee, October 1, 2001.

[240] S.C. 2001. c. 25.

[241] Brian Flagel, Director, Customs Border Services, Vancouver International Airport District, Canada Customs and Revenue Agency, Testimony before the Committee, December 3, 2001.

Canada Police were disbanded in 1997. The Committee was told that security for the Port of Montreal is provided by an agency under contract to the port authority, having neither the power nor the mandate to do law enforcement. Although the Montreal Police respond to calls, they do not patrol the Port of Montreal.[242] For the past four years, a joint forces operation of the RCMP, Sûreté du Québec, Montreal Urban Community Police, and CCRA has been responsible for conducting investigations into organized criminal activities in the Port of Montreal. Representatives from that group told the Committee they would like to see the reinstatement of police patrols in the Port of Montreal.[243] Insofar as the west coast is concerned, Deputy Chief Peter Ditchfield of the Organized Crime Agency of British Columbia told the Committee "[t]he seaports of British Columbia have long been infiltrated by organized crime groups. They are used to facilitate the importation of many types of illicit drugs, the most prominent being cocaine and heroin."[244]

Following examination of the state of security in Canada's ports, a February 2002 Report of the Standing Senate Committee on Security and Defence made similar findings with respect to the lack of an active police presence, at least in the Port of Montreal, and cited evidence that a "sizable" proportion of dockworkers had criminal records. The Report of the Standing Senate Committee recommended compulsory background screening of employees or potential employees in order to detect possible security risks.[245]

Although it is unclear whether other major Canadian ports are faced with the same problems, it is apparent that organized crime activities have undermined the security of the ports of Montreal and Vancouver and pose a very real threat to Canadians. It also appears that joint policing efforts are beginning to make headway in curtailing those criminal activities. However, the Committee believes that effective law enforcement efforts in Canada's ports will require more resources and/or greater integration in order to respond to ever increasing security and interdiction concerns, whether in the form of a dedicated police force or more effective coverage from existing forces.

4.1 COMMITTEE OBSERVATION — BORDER CONTROL

The Committee observed the following:

√ *Canada must improve the effectiveness of its border control activities and efforts to interdict illicit substances, without disrupting unduly the efficient movement of legitimate trade.*

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[242] Pierre Primeau, RCMP, Montreal Organized Crime Task Force, Testimony before the Committee, November 21, 2001.

[243] Ibid.

[244] Testimony before the Committee, December 3, 2001.

[245] *Canadian Security and Military Preparedness*, 5th Report of the Standing Senate Committee on National Security and Defence, February 2002, p. 112.

RECOMMENDATION 36

The Committee recommends that the Minister of National Revenue improve the effectiveness of interdiction efforts by ensuring that the necessary resources, including state-of-the-art contraband detection equipment, are allocated to border control activities.

RECOMMENDATION 37

The Committee recommends that the Royal Canadian Mounted Police and Canada Customs and Revenue Agency be directed to make the additional contributions necessary to provide more effective drug interdiction at major ports, in consultation with local law enforcement agencies.

5. ORGANIZED CRIME

> *The drug trade continues to be a major source of revenue for most organized crime groups. Estimates are that approximately 80% of their funding is from drug trafficking. Ecstasy has joined cannabis, heroin, and cocaine as the most popular commodities within Canada. The Canadian illicit drug market has the potential to generate proceeds between $4 billion and $18 billion at street level. The Organized Crime Agency of British Columbia has estimated that the "B.C. bud" industry is valued at about $6 billion annually.*[246]

Deputy Chief Ditchfield confirmed the importance of the British Columbia marijuana industry, citing an estimated 15,000 to 20,000 grow operations in the lower mainland of British Columbia, the profits from which "fuel the engine of organized crime in this province and provide funds for the importation and manufacture of drugs that are much more detrimental to the health and safety of Canadians."[247]

The Committee heard evidence from law enforcement agencies and policy experts outlining the role played by organized crime in the production, importation, exportation, and distribution of all types of illicit substances, both within and outside Canada. Some also drew a link between organized crime and the financing of terrorist organizations throughout the world. While there is no disputing that organized crime is involved in the trade of illicit substances, from which it derives huge profits, the Committee found little consensus as to the policy and/or legislative reforms required to better address the issue. For example, the Committee was told that prohibition was the cause of much of the harm associated with the trade in illicit substances and organized crime.

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[246] R.G. Bob Lesser, Chief Superintendent, Drug Enforcement Branch, Federal Services Directorate, RCMP, Testimony before the Committee, October 3, 2001.

[247] Testimony before the Committee, December 3, 2001.

> *In short, it is hard to imagine policies better suited to generating and perpetuating violence, corruption, organized crime, destruction of civil liberties, needless death, misery and social dysfunction than the prohibitionist schemes that Canada's policy makers and Parliamentarians have promoted over the last 90 years.*[248]

Others vehemently disagreed with the notion that the removal of prohibitions would reduce the involvement of organized crime.

> *The illegal status of a substance is only a hindrance to criminal organizations. Profit is their motivating factor. We see these groups involved in illegal activities surrounding alcohol and tobacco.*[249]

Representatives from enforcement agencies tended toward the view that more resources and improved legislation are needed to achieve better results in the repression of illicit substance use and trafficking, as well as interdiction.

In recognition of the seriousness of the situation, Parliament has recently been involved in on-going legislative reform aimed at addressing the special problems created by organized criminal activity and money laundering. In 1995, Bill C-95 granted police additional powers to investigate and prosecute gang activities.[250] In 1999, Bill C-51 granted police officers protection from criminal liability for certain activities relating to money laundering in the course of an investigation.[251] More recently, amendments contained in Bill C-24 further strengthened *Criminal Code* provisions relating to organized criminal activity, gangs and money laundering, in response to an October 2000 report of the Sub-Committee on Organized Crime of the House of Commons Standing Committee on Justice and Human Rights.[252]

The Committee is not in favour of eliminating prohibitions against illicit substances in order to remove the economic incentives that trade might provide for organized crime. On the other hand, the Committee is not persuaded that further legislative reforms are necessary at this time, since it is too soon to gauge the results of the aforementioned *Criminal Code* and other legislative amendments. However, the Committee agrees that the implementation and results of those measures should be evaluated systematically, to determine whether additional legislative steps are required.

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[248] E. Oscapella, *Witch Hunts and Chemical McCarthyism: The Criminal Law and Twentieth Century Canadian Drug Policy*, Submission to the Committee, February 28, 2002.

[249] Superintendent Carl Busson, Officer in Charge, Drug Enforcement Branch, RCMP, Testimony before the Committee, December 3, 2001.

[250] S.C. 1997, c. 23.

[251] S.C. 1999, c. 5.

[252] S.C. 2001, c. 32.

5.1 COMMITTEE OBSERVATIONS — ORGANIZED CRIME

The Committee observed the following:

- √ *While the prohibition and regulation of controlled substances is the framework within which organized crime constructs its markets, our society is not prepared or equipped, at this time, to abandon such controls simply to pre-empt criminal activities, since unrestricted use of most controlled substances poses real health risks to people.*
- √ *We must ensure that Canada's criminal justice system has the enforcement tools necessary to confiscate huge profits taken by criminal organizations trading in illicit substances.*

RECOMMENDATION 38

The Committee recommends that a committee of the House of Commons be asked to review and evaluate the operation of the *Criminal Code* and other recently enacted legislative provisions respecting organized crime and money laundering, to ensure that enforcement agencies have the legislative powers and resources necessary to target those activities effectively.

RECOMMENDATION 39

The Committee further recommends that the *Seized Property Management Act* be amended to ensure that a percentage of the proceeds described in section 10 of the Act, respecting fines imposed and properties forfeited in connection with designated substance offences or enterprise crime offences involving illicit substances, is used to support the work of community-based organizations in implementing Canada's Drug Strategy (This measure is not intended to replace the core funding of Canada's Drug Strategy.)

CHAPTER 7: INTERNATIONAL TREATIES AND LEGISLATIVE REFORM

Any in-depth drug policy debate will inevitably lead to a discussion of the justification (or lack thereof) for using the criminal law as the primary method of repression and social control of the non-medical use of psychotropic substances. Indeed, the Le Dain Commission Report framed the issue very well in 1973:

> *The law is the chief instrument of social policy. It provides the framework for all the others. Whether we should use the law at all, and if so, to what degree, in attempting to reduce non-medical drug use is first of all a matter of principle, but it is also a pragmatic issue — whether we receive a return or benefit from the use of the law that justifies the cost. This turns on the relative effectiveness of the law in this field — the extent to which it is an effective deterrent of the behaviour involved in non-medical drug use — and also on the price which must be paid for the use of it in terms of various adverse effects on individuals and the society as a whole.*[253]

The Committee heard widely disparate answers to these questions, along with a host of recommendations, ranging from calls to legalize the possession and use of virtually all substances, to demands for additional resources and renewed dedication to the task of enforcing existing prohibitions. This Chapter will examine Canada's international treaty obligations, within the context of these recommendations.

Virtually all participants in the hearing process agreed that Canada's policy response to the problems posed by substance use is, at present, inadequate and in need of reform. Some felt that amendments to the present legal framework should be part of the response. Many who insisted that prohibition and/or criminalization causes more harm than the substances themselves favoured the removal of criminal sanctions, at least for possession and use.[254] On the other hand, some of those in favour of relaxing the present laws would distinguish between certain substances, arguing, for example, that legalizing heroin use is probably not a good idea.[255] In addition to the negative consequences of involvement with the criminal justice system, many argued that prohibition contributes to the marginalization of substance users who may have difficulty obtaining much-needed health care and social services as a result.[256]

Those at the opposite end of the spectrum are worried that a relaxation of present laws would lead to widespread increases in use. They were generally unwilling to concede failure on the part of the present system, expressing the view that "Canada's existing laws have been successful in limiting the harm caused by illicit drug use" and, consequently, "[w]e need to reinforce a balanced approach that instills meaningful and proportionate consequences for serious crime, combined with measures to reinforce desired behaviour in our young people."[257] Those in favour of maintaining the legislative status quo generally believe that prohibition operates as a deterrent to many and could be more effective with increased enforcement efforts.

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[253] *Final Report of the Commission of Inquiry Into the Non-Medical Use of Drugs*, Information Canada, Ottawa, 1973, p. 47.

[254] Diane Riley, Canadian Foundation for Drug Policy and International Harm Reduction Association, Brief to the Committee, February 18, 2002, p. 7.

[255] Robert Adamec, Testimony before the Committee, April 16, 2002.

[256] Lindsay Lyster, British Columbia Civil Liberties Association, Brief to the Committee, December 5, 2001, p. 5.

1. INTERNATIONAL TREATIES

Canada is a Party to three international Conventions negotiated under the auspices of the United Nations. These treaties form a framework within which any amendments to existing prohibitions must be considered.

(a) The Single Convention on Narcotic Drugs (1961)[258]

The 1961 Single Convention was so named because it replaced several earlier international conventions.[259] It was amended in 1972 by the Protocol Amending the Single Convention on Narcotic Drugs, 1961. The Preamble to the Convention recognizes the medical use of narcotics "to be indispensable for the relief of pain and suffering," while pointing out that "addiction to narcotic drugs constitutes a serious evil for the individual and is fraught with social and economic danger to mankind." The main purpose of the Convention is to limit the production and trade in these substances to the quantity needed to meet the medical and scientific needs of the State Parties.[260]

What is the effect of this treaty on Canada's domestic laws? According to Department of Justice Counsel, "the single convention requires that a series of activities be criminalized, most notably the cultivation, the production, the manufacture, the extraction, the preparation, the possession, the offering for sale and the sale, the purchase, the importation and the exportation of drugs."[261] Target substances are listed in Schedules to the Convention and their placement determines the level of control to which they will be subjected. Morphine, cocaine, cannabis, and cannabis resin are among those listed in Schedule I of the Convention. There are also provisions that apply specifically to the cultivation of the plants from which are derived opium, cocaine and cannabis. Parties to the Convention must supply an annual report on its application within their territory and provide "the text of all laws and regulations from time to time promulgated in order to give effect" to it.[262] The report must be made to the Secretary General and contain such information as may be requested by the Commission on Narcotic Drugs of the United Nations Economic and Social Council.

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[257] Detective Glen Hayden, Canadian Police Association, Testimony before the Committee , May 8, 2002.

[258] The full text of the *Single Convention on Narcotic Drugs, 1961* is accessible through the Web site of the International Narcotics Control Board and available online at www.incb.org/e/.

[259] Dupras, D., *Canada's International Obligations Under the Leading International Conventions on the Control of Narcotic Drugs*, Library of Parliament, October 20, 1998, p. 40.

[260] Ibid.

[261] Paul Saint-Denis, Senior Counsel, Criminal Law Policy Section, Department of Justice, Testimony before the Committee, October 1, 2001.

(b) The Convention on Psychotropic Substances (1971)[263]

In 1971, the *Convention on Psychotropic Substances* supplemented the Single Convention by placing similarly stringent controls on a number of substances not covered by the first document. They include primarily synthetic preparations of stimulants (amphetamines), depressants (e.g. benzodiazepines and barbiturates), and hallucinogens (e.g. psilocybin, LSD, etc.). Once again, the Preamble recognizes the "medical and scientific" value of those substances and the need to restrict their use to these legitimate purposes. Once again, parties are required to make an annual report to the Secretary-General on the working of the Convention in their territories and any "[i]mportant changes in their laws and regulations concerning psychotropic substances."[264]

(c) The Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988)[265]

Adopted in 1988, the Trafficking Convention was directed specifically against illicit traffic in narcotic drugs and psychotropic substances. The Preamble to this Convention cites "the links between illicit traffic and other related organized criminal activities which undermine the legitimate economies and threaten the stability, security and sovereignty of States." Article three requires Parties to "adopt such measures as may be necessary to establish as criminal offences under its domestic law," the production, manufacture, distribution, importation, exportation, sale, etc. of any narcotic drug or psychotropic substance, contrary to the provisions of the 1961 or 1971 Conventions.[266] Parties are obliged to do the same for "the possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption" contrary to the 1961 or 1971 Conventions, but subject to the individual country's "constitutional principles and the basic concepts of its legal system."[267]

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[262] United Nations, *Single Convention on Narcotic Drugs, 1961*, Article 18.

[263] The full text of the *Convention on Psychotropic Substances* is accessible through the Web site of the International Narcotics Control Board and available online at www.incb.org/e/

[264] United Nations *Convention on Psychotropic Substances*, Article 16.

[265] The full text of the *Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* is accessible through the Web site of the International Narcotics Control Board and available online at www.incb.org/e/

[266] United Nations *Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, Article 3(1)(a).

[267] United Nations *Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, Article 3(2).

2. CANADIAN DOMESTIC LAW

In light of our obligations under the three treaties discussed above, the question arises as to whether or to what degree Parties can change domestic prohibitions or penalties relating to narcotic or psychotropic substances, while remaining in conformity with these Conventions. Interpretations as to the limitations they may impose are numerous and varied, particularly with respect to cannabis products. For example, it has been argued that the intention of Article 36 of the Single Convention was "for the prohibition on possession to be limited to possession for the purposes of trafficking."[268] Conversely, the Le Dain Commission expressed the view that Article 36 of the Single Convention would oblige Canada to make possession of "cannabis, cannabis resin, and extracts and tincture of cannabis, a punishable offence."[269] Nevertheless, it is apparent that some European Parties to the three Conventions have managed to find ways to attenuate the impact of their drug laws without necessarily removing prohibitions. Examples can be found in a comparative overview of the domestic treatment of cannabis by six European countries, in a study conducted for *The Independent Inquiry on the Misuse of Drugs Act, 1971*.[270]

It may be that the legalization (or repeal of prohibitions) of any of the substances covered by the United Nations Conventions would place Parties in a position of non-compliance. That said, the impact of a small or incremental change is much less clear. For example, an official from the Department of Foreign Affairs and International Trade told the Committee "[t]he consensus view in the Department of Foreign Affairs legal community would be that it is not possible to decriminalize cannabis and to be in conformity with the three conventions." However, the same official also said "Parties do have some latitude with respect to the penalties and sanctions they can implement to be in conformity with the conventions," and the requirement to make some things criminal offences "does not limit the thresholds at which certain activities need to be criminal offences, so it would be possible to assert certain thresholds."[271] The Committee believes those comments mean that Canada does have some leeway, within the limits of the Conventions, to alter the nature of the legal consequences that may flow from offences under domestic laws like the *Controlled Drugs and Substances Act*, and/or the point at which various penalties will attach. Obviously, any movement toward legalization, decriminalisation, or a change in penalties currently affecting substances now prohibited under the CDSA would have to be considered in the context of Canada's international treaty obligations.

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[268] Dupras, p. 22.

[269] *Cannabis: A Report of the Commission of Inquiry Into the Non-Medical Use of Drugs*, Information Canada, Ottawa, 1972, p. 210.

[270] N. Dorn, A. Jamieson, *Room for Manoeuvre*, Drugscope, London, March 2000.

[271] Terry Cormier, Director, International Crime Division, Department of Foreign Affairs and International Trade, Testimony before the Committee, August 27, 2002.

The Committee recognizes that the enforcement of existing prohibitions against substances of abuse can have a dramatically negative impact on the lives of persons who are dependent upon those substances: in some instances, it may be that those consequences outweigh the harms caused by the substance itself. On the other hand, the Committee believes that the illegal status of some substances probably discourages their use by a substantial segment of the population. Furthermore, so long as the international community, including Canada's neighbours and trading partners, retains a prohibitionist scheme, one can only guess at the legal, health, and social repercussions that would flow from a dramatic policy shift on the part of any single country. Consequently, at this time, the Committee is not persuaded that any benefit that might be derived from the wholesale legalization of currently illicit substances, or even their possession for personal use, would offset the potentially harmful consequences that could result. In any event, there was certainly no consensus among Committee members to repeal any of the existing prohibitions in the *Controlled Drugs and Substances Act*.

CHAPTER 8: DRUG POLICIES ABROAD

The Special Committee travelled to the United States, Switzerland, Germany, and the Netherlands in order to experience, first-hand, policies as applied by these other countries and to consult with their experts in the field of substance use, harmful use and dependence. During these visits, the Committee conferred with drug policy experts, elected representatives, law enforcement personnel, and government officials, as well as research institutes, addictions experts, and treatment providers. This Chapter provides a brief commentary on the policies of each country, and how they are implemented, as well as a brief description of some of the more innovative, low-threshold treatment services that Committee members were able to visit.

1. THE UNITED STATES

> *Reduced to its barest essentials, drug control policy has just two elements: modifying individual behaviour to discourage and reduce drug use and addiction, and disrupting the market for illegal drugs. Those two elements are mutually reinforcing.*[272]

This White House 2002 statement on United States drug policy recognizes the need for both demand reduction and supply reduction, also one of the "basic principles" of *Canada's Drug Strategy*.[273] The same *National Drug Control Strategy* document estimates that the total economic cost of illegal drug use in the United States in 2000 was $160 billion, a 57% increase since 1992. That estimate was comprised of three major components: health care ($14.9 billion), productivity losses ($110.5 billion) and others ($35.2 billion), including crime, the criminal justice system and social welfare.[274] The same document finds it "deeply disturbing" that over 50% of high school seniors experimented with illegal drugs at least once prior to graduation and points out that "an engaged government and citizenry" was instrumental in reducing drug use in the late 1980s and early 1990s, "with declines observed among 12th graders in every year between 1985 and 1992." In an attempt to recover lost ground, the 2002 *National Drug Control Strategy* sets a two-year goal of reducing by 10% current use of illegal drugs by youth (12 to 17-year-olds) and adult populations. The stated five-year goal is a 25% reduction in use of illegal drugs by both age groups.[275]

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[272] *National Drug Control Strategy*, The White House, February 2002, p. 4.

[273] Government of Canada, *Canada's Drug Strategy*, Health Canada, Ottawa, 1998, p. 3.

[274] *National Drug Control Strategy*, The White House, February 2002, p. 25.

[275] Ibid., p. 3.

The White House Office of National Drug Control Policy (ONDCP) was established by the *Anti-Drug Abuse Act* of 1988, "to set priorities, implement a national strategy, and certify federal drug-control budgets."[276] The office of Director of the ONDCP was later established, by executive order, as "the president's chief spokesman for drug control." The present "drug czar," John P. Walters, was sworn in on December 7, 2001.

The National Institute on Drug Abuse (NIDA) was established in 1974 and is part of the National Institutes of Health of the United States' Department of Health and Human Services. NIDA "supports over 85% of the world's research on the health aspects of drug abuse and addiction."[277] NIDA promotes and conducts clinical and epidemiological research "aimed at developing practical treatments, prevention strategies, and educational efforts to address the problems of drug addiction and abuse."[278] It is important to note that NIDA has supported numerous research projects relating to substance use, in Canada, as well as in other countries.

The *Controlled Substances Act* (CSA) is the major federal legislative instrument of control over licit and illicit substances in the United States.[279] The CSA places controlled substances into five Schedules, based on the substance's "medical use, potential for abuse, and safety or dependence liability."[280] For example, Schedule I substances, including heroin, marijuana, psilocybin, LSD, etc., are those deemed to have a high potential for abuse and no accepted medical use. Schedule II substances, like morphine, codeine, and some stimulants and depressants, have a medically accepted use, albeit with a "high abuse potential."[281] Although many states have adopted most provisions of the *Uniform Controlled Substances Act (1994)*, sentences vary and some states have laws supporting the medical use of marijuana.[282]

Although there is no doubt that the official federal policy in the United States promotes a prohibition model and is focused on strategies to reduce the use of all illicit substances, it would be wrong to suggest that there are no dissenting voices in areas of policy, treatment or law enforcement. For example, the governor of New Mexico has called the war on drugs a failure and promoted treatment as the preferred response to substance abuse. There are also national organizations, like the Drug Policy Alliance, that are dedicated to developing "public health alternatives to the criminal justice-based policies promoted by the war on drugs."[283] Arguing that "drug abuse is bad but the drug war is worse," the Drug Policy Alliance advocates for treatment instead of incarceration, as well as drug laws that are based on the relative harms associated with a given substance.

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[276] This information is taken from the Web site of the Office of National Drug Control Policy, and is available online at www.whitehousedrugpolicy.gov/about/legislation.html.

[277] This information is taken from the Web site of the National Institute on Drug Abuse and is available online at www.drugabuse.gov/NIDAHome.html.

[278] Ibid.

[279] *Comprehensive Drug Abuse Prevention and Control Act of 1970*, Title II, 21 U.S.C.

[280] This information is taken from the *Controlled Substances Security Manual* of the United States Drug Enforcement Administration, available online at www.deadiversion.usdoj.gov/pubs/manuals/sec/index.html.

[281] Ibid.

[282] The text of the *Uniform Controlled Drugs and Substances Act (1994)* is posted on the Web site of the National Conference of Commissioners on Uniform State Laws, available online at www.nccusl.org/nccusl/default.asp.

While in the United States, the Committee visited a "syringe exchange program" (SEP) operating in New York City under the auspices of the Harm Reduction Coalition (HRC). The HRC is a national organization "committed to reducing drug-related harm among individuals and communities by initiating and promoting local, regional, and national harm reduction education, interventions and community organizing."[284] Material produced by the Coalition points out that in order to receive state funding and to be authorized by the New York State Department of Health, syringe exchange programs must offer a comprehensive range of services, including treatment referrals and health education. Although some federal funds may be used for "non-exchange services" the Committee was told that there has been a ban on federal funding of SEPs since 1988. The same HRC publication also points out that, in January 2001, it became legal in New York State to purchase syringes at a pharmacy without prescription, although pharmacies cannot advertise the sale of syringes and the cost is not covered by Medicaid.

2. SWITZERLAND

> *Inevitably, the co-existence of law enforcement and therapy is not without its contradictions. Given the illegal nature of drugs and the fact that drug use is punishable, consumers are, of course, considered as criminals. On the other hand, within the field of public health, drug addicts are treated as ill people who require treatment.*[285]

Like most other western countries, Swiss law has prohibited substances not used for medical purposes since the early 1900s. Following the first wave of increased substance use in the 1960s, the *Narcotics Law* was revised in 1975 to differentiate between drug use (a misdemeanour) and drug dealing. Needle exchange programs were initiated in the early 1980s, in response to the rapid spread of HIV/AIDS among injection drug users and, by 1991, the Swiss government had approved a national program to reduce the drug problem. Known by the acronym "MaPaDro", it introduced the concept of harm reduction to the fight against substances in Switzerland.

Scientifically monitored clinical trials of controlled heroin prescription were initiated in Switzerland in 1994. By then, the "open" drug scene in Zurich was receiving worldwide publicity and political parties were calling for decriminalization of substance use, more widely available medically prescribed heroin, greater prevention, and "harsher punishment of drug traffickers."[286] That same year, the federal government declared its support for a "fourfold" drug policy model, focusing on prevention, therapy, harm-reduction and law enforcement. At the same time, organized crime was included in the penal code and "measures to counter money laundering were intensified." By 1995, the open drug scene in Zurich was "dispersed" and a second national conference had "ratified the strategic keystones of Switzerland's fourfold drugs policy."[287] The results of the heroin prescription clinical trials, published in 1997, "showed that heroin-assisted therapy was viable and that heavily dependent users who had failed to respond to other forms of therapy could achieve major physical, mental and social improvements with this approach." In October 1998, the Swiss Parliament passed a resolution allowing for controlled heroin prescription as a new form of therapy.

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[283] From the Web site of the Drug Policy Alliance, available online at www.drugpolicy.org/.

[284] Harm Reduction Coalition, *A Resource Guide for Providers*.

[285] *Swiss Drugs Policy*, Swiss Federal Office of Public Health, September 2000, p. 5.

While in Switzerland, the Committee visited KODA-1, a heroin-assisted treatment centre in Berne, operating under the auspices of the Swiss Federal Office of Public Health. In Switzerland, heroin assisted treatment (HAT) admission criteria require patients to be at least 18, with a history of at least two years of opiate addiction and at least two unsuccessful treatment attempts, as well as "deficiencies" in medical and/or social conditions.[288] Heroin is administered in a controlled setting by health care providers working under the supervision of physicians specially trained in the treatment of substance dependence.

The United Nations' *Report of the International Narcotics Control Board for 2001* notes that draft legislation is under consideration in Switzerland to decriminalize "both the non-medical consumption of cannabis and the cultivation, manufacture, production, possession, detention and purchase of cannabis as long as they constitute preparatory acts for personal consumption and have not created for third parties the opportunity to consume."[289] In its report, the International Narcotics Control Board (INCB) takes the position that the draft legislation would not be in conformity with the international drug control treaties because, if it is adopted, "the personal consumption and the cultivation, manufacture, production, possession, detention and purchase of cannabis for non-medical purposes would cease to be prohibited."[290]

3. GERMANY

Germany's drug policy until recently was guided by the 1990 "National Plan to Combat Narcotics," based on a consensus between the federal and state governments. Following the elections in September 1998, the bulk of the responsibility for Germany's federal involvement in formulating drug policy passed from the Interior Ministry to the

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[286] Ibid., p. 10.

[287] Ibid.

[288] Dr. Martin, Büechi, Deputy Head, Main Unit Substance Abuse and AIDS, Swiss Federal Office of Public Health.

[289] See pages 35 and 36. The full report is posted on the Web site of the International Narcotic Control Board and available online at www.incb.org/e/index.htm.

[290] Ibid.

Ministry for Health. In April 2001, a press release for the Federal Ministry for Health indicated that the "National Plan to Combat Narcotics" no longer corresponded to the current findings of research, or the practice of the addict assistance services and was "aimed one-sidedly at illegal drugs." Furthermore, that one-sided fixation on illegal drugs disregarded "the serious social and physical effects of the misuse of legal addictive substances." The same press release expressed the need for a new addiction and drug strategy with binding objectives and concrete measures for attaining them. A new prevention concept, which would make children and young people "strong enough to learn to handle anger, sadness and failures without reaching for the bottle, pill or other drugs" was to be key to the new strategy.[291]

Along with others in Europe, large German cities follow a policy of harm reduction. "Frankfurt, Amsterdam, Hamburg and Zurich, for example have signed the Frankfurt Resolution which states that attempts to eliminate the consumption of drugs in society has failed and, that criminal prosecution policies should be pursued which permit drug users to live a life of dignity." Injection rooms are available and federal law has been changed accordingly.[292]

A May 2002 report published by the Drug Commissioner of the Federal Government notes the opening of the 20th drug consumption room "where it is possible to inject drugs from the street under hygienic conditions."[293] Respecting a model project on heroin-based treatment, the same document reports that trials have been underway in seven towns, since March 2002, involving seriously ill long-term opioid addicts whose treatment with conventional abstinence or substitution therapies had previously been unsuccessful. The report also noted that roughly half of all opioid addicts were receiving either drug-free or substitution-based treatment.[294]

In an initial evaluation of drug consumption rooms, the Federal Ministry of Health determined that they were meeting Parliament's main objectives "to ensure the survival, to stabilize the health and to achieve the rehabilitation of a large number of persons from the target group of hard-to-reach narcotics addicts." The report also noted that "[t]he fall in the number of drug-related deaths last year is an encouraging sign that the Federal Government is on the right track with this scheme."

In force as of January 1982, Germany's *Narcotics Act* lists all the substances scheduled in the UN Conventions on Narcotic Drugs and Psychotropic Substances. Schedule I includes illicit narcotics "without medical benefit" including cannabis and heroin. Schedule II includes “narcotics which are used commercially for the manufacture of other products, particularly pharmaceuticals,” and Schedule III includes “marketable narcotic drugs available on special prescription,” including opium, morphine and methadone.[295] As is the case with Canadian legislation, the German *Narcotics Act* also regulates the legal trade, manufacture and prescription of narcotics, and contains both penal and administrative offences. German law also combats large-scale trafficking with legislation targeting organized crime and money laundering. Although consumption of narcotics is not an offence under German law, possession for private consumption can be. As a consequence of a 1994 decision of the German Federal Constitutional Court, based on “the ‘ban on excessive punishment’ inherent in German Basic Law,” possession of small amounts of cannabis for personal consumption is generally not prosecuted.[296]

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[291] *Dangerous use patterns are increasing among young people*, Federal Ministry for Health, Press release No. 7, April 26, 2001.

[292] From material published by the Australian Institute of Criminology, available online at www.aic.gov.au/research/drugs/international/germany.html.

[293] Drug Commissioner of the Federal Government, "Reforms in addict assistance achieved — new challenges to be faced," *Drug and Addiction Report*, May 2002.

[294] Ibid.

While in Germany, the Committee visited several treatment facilities in Frankfurt. One of them was “Eastside,” the largest drug aid centre in the city. Founded in 1992, in response to the “open” drug scene, Eastside provides long-term, homeless addicts with shelter, work opportunities, and “using space” (injecting rooms) as well as a bus shuttle to bring clients from the downtown area. The Committee also visited two downtown facilities of the Narcotic Emergency Centre. One of those facilities contained a substitution program and a separate “consuming facility room” for injection drug users over 18 who are not enrolled in a substitution program. Although the stated principle aim of such facilities is the prevention of narcotic-induced emergencies, they also provide clients with access to psychological and physical treatment for their addiction.

4. THE NETHERLANDS

> *Investing in a policy that aims to protect health pays for itself in terms of mortality, morbidity and the existence of marginalization. A situation like that in a number of other countries, where the mostly youthful users run the risk of coming into contact with the judicial system, is seen as highly undesirable in the Netherlands. The harm done by a criminal record is greater than the harm caused by (generally) a few years of experimental drug use.*[297]

Living in one of the most densely populated countries in the world, Dutch society is characterized by a strong belief in the separation of church (or morality) and state, and an extensive social welfare system. Dutch drug policy acknowledges drug use as a fact that must be dealt with in a practical manner, by preventing or limiting the risks or harms associated with drug use.

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[295] This information is taken from material published online by the *European Legal Database on Drugs* and is available at eldd.emcdda.org/databases/eldd_country_profiles.cfm?country=DE.

[296] Ibid.

[297] Information in this section is taken principally from a paper entitled *The Netherlands' Drug Policy*, presented to the Committee, June 20, 2002 by Bob Keizer, Senior Drug policy advisor, Ministry of Health, Welfare and Sports of The Netherlands.

Coordinated by the Ministry of Health, the Netherlands' drug policy is implemented through the *Opium Act*, which contains penalties based on the relative harmfulness of a given drug and also the nature of the offence. Possession of up to 30 grams of cannabis is a minor offence, but is generally not prosecuted. Although dealing in small amounts of cannabis is an offence, the Public Prosecutor will refrain from prosecuting outlets, known as "coffee shops," so long as there is no advertising, no sales of hard drugs, no admittance or sales to persons under 18 and no sales exceeding 5 grams per transaction. The prosecution of all other forms of dealing and production are given high priority, in a manner comparable to neighbouring European countries.

In order to treat more effectively those addicts who are in poor physical condition or have psychiatric problems, the Netherlands is conducting heroin prescription trials, involving approximately 600 substance-dependent individuals, with evaluation results expected in 2003. To deal with the social and judicial nuisance created by a small group of users, the government has also developed better shelter facilities and experimental user rooms (safe injection rooms) and began experimenting with forcible treatment of hard-core "nuisance addicts" frequently convicted for petty crimes.

While in Amsterdam, the Committee consulted with staff and administrators of the Jellinek Institute. The Jellinek Institute is the oldest treatment institute for alcohol and drug addiction in the Netherlands and one of the largest in Europe. In addition to offering treatment for drug and alcohol addiction, the Jellinek also treats people with gambling problems and provides services in prevention, training and research.[298] The Committee also visited a treatment centre for substance users operated under the auspices of the Jellinek Institute, where vocational training is offered as an integral part of the recovery program.

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[298] This information was obtained from the Web site of Prevnet Network and is available online at www.prevnet.net/members/jellinek.html.

CHAPTER 9: CANNABIS

1. MANDATE OF THE SPECIAL COMMITTEE ON NON-MEDICAL USE OF DRUGS

As explained in Chapter 1, the Special Committee on Non-Medical Use of Drugs was initially mandated to study "the factors underlying or relating to the non-medical use of drugs in Canada" and to bring forward recommendations aimed at reducing "the dimensions of the problem involved in such use." That mandate was expanded on 17 April 2002 when the House of Commons, by order of reference, added the subject matter of Private Member's Bill C-344, *An Act to amend the Contraventions Act and the Controlled Drugs and Substances Act (marihuana)*.[299] This chapter will consider the provisions of the *Controlled Drugs and Substances Act* (CDSA) only as it relates to the criminal prosecution of cannabis offences.[300]

Bill C-344 proposed to amend the *Controlled Drugs and Substances Act* and the *Contraventions Act*, to make the offences of possession, possession for the purposes of trafficking and trafficking in small amounts of cannabis (one gram or less of cannabis resin and thirty grams or less of cannabis (marijuana)) "ticketable" offences. The available penalties would be a $200 fine for a first conviction, $500 for a second and $1,000 for a third. At present, possession of those amounts is a summary conviction offence with a maximum penalty of a $1,000 fine or six months in jail, or both. Today, trafficking of anything less than 3 kg of cannabis resin or marijuana is exclusively indictable and carries a maximum penalty of 5 years less a day imprisonment.[301] In support of his bill, Dr. Martin argued that it would unburden the courts, save money, and free up police resources to combat more serious offences.

2. LEGISLATIVE OPTIONS

The Committee heard a wide variety of suggestions respecting the legal treatment of cannabis. Some recommended legalization, either regulated or unregulated. Others favoured some form of decriminalization that would create a non-criminal offence of possession, while still others preferred a more cautious approach that would retain present prohibitions, while introducing more and better diversion options as a way of avoiding some of the harms associated with prosecution. There were also those who favoured increased penalties, at least for trafficking offences, and a renewed commitment to the goal of abstinence. For their part, some health care professionals thought that more research into the effects of cannabis should be undertaken before amending the law, in order to bring better information to the debate, while others pointed out that the illegal status of cannabis has contributed to "a real resistance to conducting those sorts of studies."[302]

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[299] Introduced on 4 May 2001 by Dr. Keith Martin, M.P. (Esquimalt—Juan de Fuca). An earlier version of the bill was given first reading on 26 October 1999; see Bill C-266, 2nd Session, 36th Parliament.

[300] Because this is a study of the non-medical use of drugs, the adequacy and operation of the *Medical Marijuana Access Regulations* will not be included in the discussion

[301] Trafficking or possession for the purposes of trafficking, in amounts in excess of 3 kg, is a purely indictable offence, punishable by a maximum of life imprisonment; see sections 5(1), (2) and (3) of the *Controlled Drugs and Substances Act*.

For the purposes of this discussion, the Committee defines *legalization* as the removal of all criminal sanctions prohibiting the production, sale or possession of a given substance. Legalization need not be accompanied by the removal of all regulatory controls. In fact, the ability to regulate production and supply, to tax, and to limit access by age, are often cited as major advantages of legalization. The Committee uses the term *decriminalization* to refer to the removal of *criminal* sanctions for certain activity while retaining legal prohibitions. Decriminalization would allow continued criminal prosecution of many or most actions relating to an illicit substance like cannabis, while allowing possession of small amounts of the same substance for personal use to be treated as a regulatory offence, with consequences not unlike those attached to minor motor vehicle infractions under provincial legislation. Under such a scheme, prosecution of the new regulatory offence could be initiated by issuance of a ticket, fines could be paid without a court appearance, and enforcement would not result in a criminal conviction.

The Committee heard from witnesses who expressed the view that the prosecution of cannabis-related offences takes up too much of our scarce criminal justice resources. The potentially negative impact of a criminal conviction was often given as another reason for changing the law. The possibility of uneven or inconsistent enforcement of existing laws may also lend support for legislative changes, to ensure that some individuals don't end up with a large fine and a criminal conviction for possession of a small amount, while others are simply warned and/or have their cannabis confiscated. Although some witnesses argued that enforcement agencies no longer target cannabis possession, preferring instead to pursue more serious CDSA charges, recent crime statistics make clear that possession still constitutes the majority of cannabis incidents reported. For example, Statistics Canada noted that cannabis accounted for about three-quarters of all 91,920 drug-related incidents reported by Canadian police services in 2001. Moreover, 70 percent of those cannabis incidents were for possession.[303]

The following arguments are often made in support of legalization;

- criminal sanctions that do not have the support of a strong majority of the population lead to a loss of respect for the law and those responsible for enforcing it;

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[302] Eugene Oscapella, Canadian Foundation for Drug Policy and Harm Reduction Network, Testimony before the Committee, February 28, 2001.

[303] Josée Savoie, "Crime Statistics in Canada, 2001," *Juristat*, Statistics Canada, Canadian Centre for Justice Statistics, Catalogue no. 85-002-XIE Vol. 22 no.6, p. 11.

- the illicit status of cannabis results in users being exposed to traffickers who also deal in more harmful substances (the need for "separation of markets" has been cited as a principle reason for the existing cannabis policy in the Netherlands);[304]
- legalization also permits regulation and taxation, along with the ability to limit access on the basis of age.

On the other hand, the following reasons are most commonly cited by those who are opposed to legalizing cannabis;

- removing prohibitions would send the wrong message by normalizing use, especially for young people.[305] As an example, many argue that the current publicity around medical use of marijuana has already been perceived by some as an endorsement of the healthful effects of the drug;
- cannabis acts as a "gateway" to the use of other more harmful drugs, if not directly through dependency, then indirectly, through the social milieu and risk-taking aspects of the behaviour.[306]

A majority of members of the Committee are persuaded that there is a need to reform the legislation respecting cannabis, for a variety of reasons. We agree, for example, that because enforcement of the law appears to be sporadic, uneven, and subject to regional discrepancies, its application is likely to be inconsistent and unfair. We further agree that the consequences of a criminal conviction for simple possession of a cannabis product are disproportionate to the potential harms associated with personal use. This is especially true when one considers the harm caused every day by the use of licit substances like tobacco, alcohol, and some common non-prescription medications.

However, the Committee shares the concern expressed by many educators, treatment providers, and law enforcement officers to name only a few, that many Canadians, and youth in particular, might misperceive legalization as evidence that Parliament is not concerned about the widespread use of cannabis. At least as far as this Committee is concerned, nothing could be further from the truth. Indeed, the Committee was told by various health care professionals, addictions specialists and treatment providers that frequent and prolonged use of cannabis can lead to dependence as well as social problems for certain users. In addition, Dr. Mark Zoccolillo expressed concern about the frequency of marijuana use among students he studied, the resulting potential for the disruption of short-term or "working memory," and the long-term consequences for that particular age group. Furthermore, the Committee is not convinced that legalization accompanied by regulation would remove the profit from the illegal production and sale of cannabis or in any significant way discourage criminals currently involved in distribution.

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[304] This theory rests on the argument that, given legal access to a substance like cannabis, would-be purchasers are no longer forced to consort with criminals, many of whom may also be involved in the sale of much more harmful substances.

[305] Ernie Howe, Addictions Services-Outpatient, Testimony before the Committee, May 23, 2002.

[306] Corporal Ken Murray, RCMP, Testimony before the Committee, April 15, 2002.

For those reasons, the Committee would prefer to see cannabis offences retained in the *Controlled Drugs and Substance Act*, but with simple possession decriminalized by designation as a "contravention," much like the scheme proposed in Bill C-344.[307] However, unlike the amendments proposed in Bill C-344, we do not support a lessening of the penalties for any form of trafficking or possession for the purposes of trafficking. Thus, our preference would be to mandate proceeding against incidents of possession and/or cultivation for personal use by ticketing, except where the offence is committed in the presence of specified aggravating circumstances. For example, in recognition of the safety and policing concerns expressed by law enforcement agencies, the Committee believes that possession charges linked to impaired driving offences should continue to be prosecuted as a criminal offence under the CDSA.[308] Implementation of these proposals may require a redrafting of the possession offences in the CDSA, in order to retain present penalties for 'aggravated' possession charges.

The Committee deliberated at considerable length over the question of whether criminal sanctions should be retained for simple possession of cannabis in relation to schools and other places frequented by youth. However, most Committee members were reluctant to propose a scheme that operates more onerously against youth than it does against their adult counterparts. Furthermore, trafficking, or possession for the purposes of trafficking, in or near a school or other place frequented by those under eighteen, and trafficking to persons under eighteen, are already "aggravating factors" to be considered at the time of sentencing. Because trafficking-related offences and penalties will not be affected by the decriminalization scheme we propose, those provisions will continue to apply. Therefore, the Committee proposes that possession of a small amount of cannabis for personal use, even on school property, should also be a "ticketable" offence under the new scheme. The Committee expects that school boards will continue to impose their own administrative controls, as necessary, to further deter students from bringing cannabis onto school property in much the same way as they do now with other substances.

By designating as contraventions, those offences relating to the possession or cultivation of small amounts of cannabis for personal use, the proposed decriminalization scheme would leave existing criminal sanctions in place to allow the full force of the law to continue to be brought to bear against anyone who traffics in or cultivates cannabis products for profit. Retaining a criminal offence for possession of cannabis in association with an impaired driving offence would do the same for those individuals whose substance use risks grave and substantial harm to others. Finally, decriminalization would have the added benefit of maintaining Canada's compliance with the International Conventions discussed in Chapter 7.

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[307] To be logically consistent, it may also be advisable to deal with cultivation for personal use in the same manner if that is practically and administratively possible.

[308] Chief Superintendent Bob Lesser, Drug Enforcement Branch, Federal Services Directorate, RCMP, Testimony before the Committee, October 3, 2001.

3. COMMITTEE OBSERVATIONS — CANNABIS

The Committee observed the following:

√ *Smoking any amount of marijuana is unhealthy, because of its high concentration of tar and benzopyrene.*

√ *The consequences of conviction for possession of a small amount of cannabis for personal use are disproportionate to the potential harm associated with that behaviour.*

√ *DECRIMINALIZING the possession of small amounts of cannabis for personal use would not affect the penalties or consequences for trafficking, or for the possession of any other controlled substance.*

√ *All orders of government must undertake to inform Canadians about the potential harms associated with cannabis use and, in particular, the heightened risk to young persons.*

RECOMMENDATION 40

The Committee recommends that the possession of cannabis continue to be illegal and that trafficking in any amount of cannabis remain a crime.

RECOMMENDATION 41

The Committee recommends that the Minister of Justice and the Minister of Health establish a comprehensive strategy for decriminalizing the possession and cultivation of not more than thirty grams of cannabis for personal use. This strategy should include:

- **Prevention and education programs outlining the risks of cannabis use and, in particular, the heightened risk it poses to young persons; and**
- **The development of more effective tools to facilitate the enforcement of existing *Criminal Code* prohibitions against driving while impaired by a drug.**

APPENDIX A: LIST OF RECOMMENDATIONS

CHAPTER 3: CANADA'S DRUG STRATEGY

RECOMMENDATION 1

The Committee recommends that the Government of Canada reaffirm its commitment to addressing the use and harmful use of substances and dependence, by developing, in consultation with provincial/territorial governments and key stakeholders, a renewed, comprehensive, coordinated and integrated Canadian drug strategy to address the use of illicit substances and licit (or legal) substances such as alcohol, tobacco, inhalants and prescription drugs.

RECOMMENDATION 2

The Committee recommends that a renewed Canada's Drug Strategy include clear, measurable goals and objectives as well as a process for evaluation and accountability, and, with these components in place, that adequate and sustained funding be allocated.

RECOMMENDATION 3

The Committee recommends the appointment of a Canadian Drug Commissioner, statutorily mandated to monitor, investigate and audit the implementation of a renewed Canada's Drug Strategy and to report and make recommendations annually to Parliament, through the Speaker of the House of Commons.

RECOMMENDATION 4

The Committee recommends that the Minister of Health be mandated to coordinate the multi-departmental implementation of a renewed Canada's Drug Strategy and to respond to the Canadian Drug Commissioner's report within 90 days in an annual statement to the Standing Committee on Health, through the House of Commons.

RECOMMENDATION 5

The Committee recommends the Canadian Centre on Substance Abuse, as an independent non-governmental organization, be given the mandate to develop, in consultation with federal, provincial and territorial governments and key stakeholders, the goals, the objectives, the performance indicators and the strategic plan for a renewed Canada's Drug Strategy, which shall be comprehensive, coordinated and integrated.

CHAPTER 4: RESEARCH AND KNOWLEDGE

RECOMMENDATION 6

The Committee recommends that biennial cross-Canada surveys be undertaken as part of a renewed Canada's Drug Strategy to determine the nature, prevalence and trends of all substance use in Canada.

RECOMMENDATION 7

Considering the urgent need for Canada-wide data on the use and harmful use of substances and dependence, and the costs and benefits of using a regular health survey to gather such data, the Committee recommends serious consideration be given to integrating questions on licit and illicit substances in every cycle of the Canadian Community Health Survey, every two years.

RECOMMENDATION 8

The Committee recommends that the Government of Canada's contribution to the Canadian Centre on Substance Abuse (CCSA) be immediately increased to $3 million, with subsequent annual increases to be determined based on the recommendations of the Canadian Drug Commissioner following an annual review and audit of the needs and activities of the CCSA.

RECOMMENDATION 9

The Committee recommends that the Institute of Neurosciences, Mental Health and Addiction increase its focus on addictions research.

RECOMMENDATION 10

The Committee recommends that the Government of Canada, under a renewed Canada's Drug Strategy, provide Health Canada with dedicated research funds to:

- Ensure the systematic and regular collection, retrieval and integration of regional, provincial and Canada-wide data on the use and harmful use of substances, and dependence;

- Sustain research initiatives on key issues related to the use and harmful use of substances, and dependence; and
- Increase funding of addictions research through the Institute of Neurosciences, Mental Health and Addiction of the Canadian Institutes of Health Research.

RECOMMENDATION 11

The Committee recommends that Health Canada, in consultation with the Canadian Centre on Substance Abuse and key stakeholders, including substance users, identify research priorities to be supported by dedicated research funds under a renewed Canada's Drug Strategy.

CHAPTER 5: THE USE AND HARMFUL USE OF SUBSTANCES: PUBLIC HEALTH ISSUES

RECOMMENDATION 12

The Committee recommends that the Government of Canada, under a renewed Canada's Drug Strategy, provide sustained funding and resources to develop and implement health-based public awareness, prevention and education programs related to the use and harmful use of substances and dependence, in collaboration with provincial, territorial, municipal authorities and community-based organizations.

RECOMMENDATION 13

The Committee recommends that the Government of Canada, under a renewed Canada's Drug Strategy, allocate funds to develop and implement effective Canada-wide mass media prevention and education campaigns related to the use and harmful use of substances and dependence.

RECOMMENDATION 14

The Committee recommends that the Government of Canada, under a renewed Canada's Drug Strategy, support the development of up-to-date information on the use and harmful use of substances and dependence, and of appropriate training for the benefit of healthcare professionals and all service providers involved in the field of addictions, in collaboration with provincial and territorial governments.

RECOMMENDATION 15

The Committee recommends that a renewed Canada's Drug Strategy explicitly recognize the concept of and contribute toward a continuum of care, including low-threshold services, long-term treatment and recovery services, which would integrate the provision of social services as an essential element of treatment and rehabilitation.

RECOMMENDATION 16

The Committee recommends that a renewed Canada's Drug Strategy include abstinence as one of the wide range of successful treatment options that currently exist.

RECOMMENDATION 17

The Committee recommends that a renewed Canada's Drug Strategy explicitly recognize the need to provide treatment services in a timely manner and that these services be sensitive to socio-economic, gender and cultural diversity.

RECOMMENDATION 18

The Committee recommends the development and delivery of treatment services adapted for individuals with Fetal Alcohol Syndrome/Fetal Alcohol Effect (FAS/FAE) or mental health disorders concurrent with the harmful use of substances and dependence.

RECOMMENDATION 19

The Committee recommends that a renewed Canada's Drug Strategy include "substitution treatment" such as methadone maintenance as part of a comprehensive approach to the treatment of opiate addiction that includes primary health care, counselling, education and other social services.

RECOMMENDATION 20

The Committee recommends that the proposed clinical trials pilot project in Vancouver, Toronto and Montreal to test the effectiveness of heroin-assisted treatment for drug-dependent individuals resistant to other forms of treatment be implemented and that these trials incorporate protocols for rigorous scientific assessment and evaluation.

RECOMMENDATION 21

The Committee recommends the removal of federal regulatory or legislative barriers to the implementation of scientific trials and pilot projects to determine the effectiveness of new and innovative methods in the treatment of individuals who have developed a pattern of harmful use of substances and dependence.

RECOMMENDATION 22

The Committee recommends that the Government of Canada encourage and assist the provincial, regional and municipal authorities to integrate and deliver needle exchange programs through a public health care model including primary health care services as well as prevention and education, counselling, treatment and rehabilitation programs.

RECOMMENDATION 23

With regard to safe injection facilities, the Committee recommends that the Government of Canada remove any federal regulatory or legislative barriers to the implementation of scientific trials and pilot projects, and assist and encourage the development of protocols to determine the effectiveness of safe injection facilities in reducing the social and health problems related to injection drug use.

RECOMMENDATION 24

The Committee recommends that clear quantitative and qualitative goals be incorporated into all services related to the harmful use of substances, and dependence, together with a performance evaluation process to ensure that prevention, education, treatment, rehabilitation and harm reduction programs are evidence-based and reflect best practices.

RECOMMENDATION 25

The Committee recommends that Canada's Drug Strategy identify harm reduction as a core component of Canadian drug policy that supports interventions to maintain the health of individuals and minimize the public health risks associated with substance use.

RECOMMENDATION 26

The Committee recommends that a renewed Canada's Drug Strategy include in its priorities the development of a strategy relating specifically to the misuse of over-the-counter and prescription drugs in Canada.

RECOMMENDATION 27

The Committee recommends that the Government of Canada assist and encourage the provinces and territories in the development and maintenance of comparable real-time databases so as to track better the prescribing and dispensing of commonly misused prescription drugs.

CHAPTER 6: SUBSTANCE USE AND PUBLIC SAFETY

RECOMMENDATION 28

The Committee recommends continued support for existing Drug Treatment Court pilot projects and, if indicated by evaluation outcomes, the Committee further recommends permanent funding of those Courts, with support for additional sites.

RECOMMENDATION 29

The Committee recommends that the Minister of Health and the Minister of Justice propose appropriate amendments to the *Controlled Drugs and Substances Act* and/or the *Criminal Code* to provide a wider range of sentencing options, including treatment, for substance-dependent individuals involved with the criminal justice system.

RECOMMENDATION 30

The Committee recommends that Correctional Service Canada be required to develop and implement a three-year plan to reduce substantially the flow of illicit drugs into prisons. The Committee further recommends that the proposed Canadian Drug Commissioner be consulted in setting the goals of the plan and responsible for monitoring results.

RECOMMENDATION 31

The Committee recommends that Correctional Service Canada provide incarcerated offenders with access to substitution therapies, such as methadone, based on eligibility criteria similar to those used in the community at large.

RECOMMENDATION 32

The Committee recommends that Correctional Service Canada allow incarcerated offenders access to harm-reducing interventions, in order to reduce the incidence of blood-borne diseases, in a manner consistent with the security requirements within institutions.

RECOMMENDATION 33

The Committee recommends that Correctional Service Canada continue to promote abstinence as its overriding treatment objective.

RECOMMENDATION 34

The Committee recommends that Correctional Service Canada undertake, as a pilot project, the establishment of two federal correctional facilities reserved for offenders who wish to serve their sentence in a substance-free environment with access to intensive treatment and support.

RECOMMENDATION 35

The Committee urges Correctional Service Canada to ensure that there are sufficient programs and spaces available to allow offenders access to treatment for substance use, as needed, immediately following their incarceration.

RECOMMENDATION 36

The Committee recommends that the Minister of National Revenue improve the effectiveness of interdiction efforts by ensuring that the necessary resources, including state-of-the-art contraband detection equipment, are allocated to border control activities.

RECOMMENDATION 37

The Committee recommends that the Royal Canadian Mounted Police and Canada Customs and Revenue Agency be directed to make the additional contributions necessary to provide more effective drug interdiction at major ports, in consultation with local law enforcement agencies.

RECOMMENDATION 38

The Committee recommends that a committee of the House of Commons be asked to review and evaluate the operation of the *Criminal Code* and other recently enacted legislative provisions respecting organized crime and money laundering, to ensure that enforcement agencies have the legislative powers and resources necessary to target those activities effectively.

RECOMMENDATION 39

The Committee further recommends that the *Seized Property Management Act* be amended to ensure that a percentage of the proceeds described in section 10 of the Act, respecting fines imposed and properties forfeited in connection with designated substance offences or enterprise crime offences involving illicit substances, is used to support the work of community-based organizations in implementing Canada's Drug Strategy (This measure is not intended to replace the core funding of Canada's Drug Strategy.)

CHAPTER 9: CANNABIS

RECOMMENDATION 40

The Committee recommends that the possession of cannabis continue to be illegal and that trafficking in any amount of cannabis remain a crime.

RECOMMENDATION 41

The Committee recommends that the Minister of Justice and the Minister of Health establish a comprehensive strategy for decriminalizing the possession and cultivation of not more than thirty grams of cannabis for personal use. This strategy should include:

- **Prevention and education programs outlining the risks of cannabis use and, in particular, the heightened risk it poses to young persons; and**
- **The development of more effective tools to facilitate the enforcement of existing *Criminal Code* prohibitions against driving while impaired by a drug.**

APPENDIX B: TERMS OF REFERENCE

INTRODUCTION

On 17 May 2001, the House of Commons gave the Special Committee a very broad mandate to study "the factors underlying or relating to the non-medical use of drugs in Canada" and to bring forward recommendations aimed at reducing "the dimensions of the problem involved in such use."

To date, the Committee has reviewed a sampling of the relevant literature and received briefings from various government departments responsible for implementing Canada's Drug Strategy. As a result of this preliminary work, the Committee is aware of the potential breadth of the study to be undertaken. In addition to the problems relating to a wide variety of illicit drugs such as heroin, cocaine and marijuana, to name only a few, a truly comprehensive study of the non-medical use of drugs could also include tobacco and alcohol, as well as the misuse of "licit" prescription and non-prescription drugs. Indeed, studies have shown that the overall societal costs of tobacco and alcohol use outstrip those of all illicit psychotropic substances combined.

However, the Committee is keenly aware of the urgent need to address some of the worst problems associated with substance abuse in Canada and the significant time constraints under which it will be operating in order to table a Report in the House of Commons by November 2002. Therefore, rather than undertaking a detailed review of selected drugs and the people who use them, the Committee believes that a more generic approach is necessary. Consequently, this study will examine substance abuse in its various contexts, with a view to determining the ways in which it interferes with the health and security of users, their communities and society as a whole, in order to suggest appropriate responses. Bearing in mind the need to harmonize policy with domestic laws and international commitments, the Committee will also note which, if any, legislative reforms it considers necessary to achieve that end.

While the Committee has no wish to limit the scope of its recommendations, there are factors that may influence the focus of its final report. For example, the Senate Special Committee on Illegal Drugs is mandated to examine laws and policies respecting Cannabis and to table its report by August 2002. Depending upon the scope and substance of that report, the House of Commons Special Committee on Non-Medical Use of Drugs or may or may not find it necessary to elaborate further on matters relating to marijuana.

The following issues are intended to focus discussions with expert witnesses, stakeholders and the public at large. Although the Committee expects to address many of these issues during the course of its study, the list is not intended to be exhaustive or limiting, since other worthwhile approaches may yet be identified. However, the Committee anticipates that the following will act as a guide to assist interested parties in the preparation of submissions.

CANADA'S DRUG STRATEGY

According to its own description, Canada's Drug Strategy reflects "a balance between reducing the supply of drugs and reducing the demand for drugs." Its stated goal is "to reduce the harm associated with alcohol and other drugs to individuals, families, and communities." Direct responsibility for the implementation of Canada's Drug Strategy is shared among numerous federal Departments and Agencies, with Health Canada taking the lead. For example, Justice Canada is responsible for drug prosecutions, while the R.C.M.P. enforces the laws intended to reduce the supply of drugs and Correctional Service Canada administers drug-related sentences and provides treatment to offenders with substance abuse problems. In light of the challenges involved in coordinating the efforts of so many different groups, the question arises whether a more centralized approach within the federal government could achieve better results in the long run. The Committee anticipates that this year's Annual Report of the Auditor General will help to answer that question, given that it is expected to include a review of Canada's Drug Strategy and, more particularly, the federal government's role in reducing the harm caused by illicit drugs.

In consideration of the efficacy of Canada's Drug Strategy thus far, the Committee welcomes comment on the following questions.

- Does the office of Canada's Drug Strategy monitor efforts in research, education or pilot treatment projects undertaken by partner federal agencies, provincial governments or non-governmental organizations? Does the office of Canada's Drug Strategy compile data on related program expenditures by partner federal departments and agencies? Is there a single entity that could act as a source of information on all federal programs currently funded as part of Canada's Drug Strategy?

- What financial resources are dedicated to the implementation of Canada's Drug Strategy and are there areas where more money needs to be invested? What is the appropriate role for the federal government in implementing drug policy? Are there areas where greater federal intervention would be welcome?

- Does the current administrative framework of Canada's Drug Strategy lead to a fragmentation of effort and results? Are there conflicting interests among responsible departments and agencies? Could Canada's Drug Strategy be more effectively administered by a single, dedicated agency, operating independently of other government departments? Alternatively, could a higher profile and a more focused approach be achieved through the appointment of a national spokesperson for Canada's Drug Strategy? Is Canada's Drug Strategy working? What has it accomplished to date?

EXPANDING THE KNOWLEDGE BASE

In the short time that the Committee has had to consider the scope of its mandate, members have become aware of the absolute necessity of having reliable data on which to base the myriad policy decisions necessary for developing and administering a cohesive and viable drug strategy in Canada. At the same time, the lack of up to date reliable national data on usage patterns has also become apparent. Without such data, timely reaction to developing trends may be difficult if not impossible. The Committee will consider the current situation in Canada as it relates to the conduct and funding of research and data collection, to determine whether additional resources are needed to facilitate and support informed policy choices.

- Is there a need for more and better data collection on drug use in Canada? A number of provinces conduct regular surveys of drug usage by secondary school students, some more frequently than others. Are there comparable data respecting drug use by the population as a whole? Do we have reliable data on drug use among other population sub-sets who may be at greater risk for some of the harms associated with substance abuse? Are there sufficient data to enable timely identification of trends or shifts in drug use?

- Who is currently conducting research on the use and abuse of psychoactive substances in Canada? How much of the funding for that research is provided by the federal government? What level of funding comes from each of the provincial governments? Are there any other sources of support?

- The Canadian Institutes of Health Research (CIHR) is a federal agency comprised of thirteen different institutes, each of which funds research and training in a particular area. The Institute of Neurosciences, Mental Health and Addiction allocates research funds to a vast array of health concerns that currently include mental health, neurological health, vision, hearing, and cognitive functioning. They also support research to reduce the burden of related disorders through prevention strategies, screening, diagnosis, treatment, support systems and palliation. Addiction prevention policies and strategies is one research area among many others that the Institute supports. Given the scope and consequences of problems relating to substance use and misuse in Canada, is there an argument for creating a Research Institute within CIHR, dedicated solely to research on addictions?

DEFINING AND ENHANCING HARM REDUCTION

A "harm reduction" approach to the treatment and management of substance abuse gained popularity during the 1980's, when the spread of HIV/AIDS came to be viewed as a greater threat to individual and public health than drug use. Although initially directed toward injection drug use, many jurisdictions have since adapted the harm reduction approach to other illicit drugs, as well as legal substances like alcohol and tobacco. According to Canada's Drug Strategy, harm reduction is a "realistic, pragmatic, and humane approach" to substance abuse, "as opposed to attempting solely to reduce the use of drugs." However, there is a distinct lack of consensus on whether harm reduction is limited to reducing the adverse consequences of drug use, or whether that approach can extend to policies aimed at preventing or reducing the use of drugs. In an attempt to take the broadest possible view of this ongoing debate, the Committee will consider the following questions as they may relate to harm reduction.

- How much does criminalization contribute to the harm associated with drug use? Are there ways to mitigate those adverse effects? If prohibition doesn't eliminate drug abuse, does it at least discourage use among the general population? Are Canada's drug laws and policies in need of review and reform? What role should law enforcement agencies play in harm reduction?

- Is treatment for drug addiction or dependence readily available in all jurisdictions? Are there barriers to access for those in need of treatment? Are treatment programs available in correctional facilities? Can existing social programs provide the additional supports necessary for individuals involved in drug treatment or rehabilitation?

- What kinds of educational programs are aimed at preventing or reducing the consumption of illicit drugs in Canada? How does the level of funding and scope for those compare with programs devoted to the prevention of smoking or alcohol abuse? What has been the role of the provinces in education and prevention? Are there promising innovations in other jurisdictions that Canada should consider? Is there realistic and honest drug education focused on health and well-being?

- Canada's Drug Strategy espouses elements of "harm reduction" in the management of substance use and abuse. How much does the success of that approach rely on the support of a well-informed public? Has Health Canada or any other federal Department or Agency undertaken public education initiatives explaining the benefits of the harm reduction policies it currently supports?

ADDRESSING INJECTION DRUG USE

It is apparent from the debate on the motion leading to the formation of this Committee that injection drug use is a major concern for members of the House of Commons and their constituents. The scope of the problem of injection drug use and its consequential health effects was the subject of a recent Federal/Provincial/Territorial Advisory Committee Report entitled *Reducing the Harm Associated with Injection Drug Use in Canada*. Among other findings, the Report confirmed that injection drug use is a major risk factor for HIV/AIDS and Hepatitis infections, carrying potentially disastrous consequences not only for infected individuals, but also their communities and Canadian society as a whole. Those consequences are particularly apparent among incarcerated Canadians. In addition to recommending steps that could be taken immediately to address the problem, the Report also suggested "a close examination of Canada's drug law, regulations and policies related to injection drug use and to drug misuse in general." Bearing in mind the need for a review of existing legislation and policies, the Committee will consider the following questions concerning injection drug use in Canada.

- Among other recommendations, the aforementioned report calls for enhancement of needle exchange programs and increased access to treatment options including methadone maintenance. The report also advocates clinical trials of prescription heroin and urges consideration of a pilot or research project involving a "supervised injection site." The Committee would like to hear submissions on those recommendations in particular. For example, what, if any, negative impacts are associated with existing needle exchange programs? Do service providers agree that there is a need for prescription heroine trials? Do law enforcement agencies have particular concerns about supervised injection sites? Is there community support for implementing these and other recommendations made in the report? If so, what other barriers are there to implementation?

- How much is known about the extent of injection drug use in all areas of Canada? Are there any groups that are at greater risk for the harms associated with this kind of drug use? Is there a need for enhanced data collection to better monitor trends, as well as outcomes of any new treatment or harm-reduction initiatives? Are there harm reduction, prevention, treatment, or law enforcement strategies that have been successful in other countries?

- The rate of injection drug use among incarcerated individuals is known to be significant. Are there prevention and treatment programs that could be better adapted to correctional facilities? Are there innovations in other jurisdictions that have proven successful within the prison environment?

APPENDIX C
LIST OF WITNESSES

Associations and Individuals	Date	Meeting
Canada Customs and Revenue Agency	01/10/2001	3
Mark Connolly, Director General, Contraband and Intelligence Services Directorate		
Michael Crichton, Chief, Intelligence Development, Intelligence and Operations Division, Contraband and Intelligence Services Directorate		
Susan Hague, Senior Program Advisor, Contraband Operations Section, Contraband and Intelligence Services Directorate		
Department of Justice		4
Croft Michaelson, Director and Senior General Counsel, Strategic Prosecution Policy Section		
Paul Saint-Denis, Senior Counsel, Criminal Law Policy Section		
Department of Health	03/10/2001	5
Cathy Airth, Acting Director, Office of Canada's Drug Strategy, Drug Strategy and Controlled Substances Program, Healthy Environments and Consumer Safety Branch		
Carole Bouchard, Director, Office of Controlled Substances, Drug Strategy and Controlled Substances Program, Healthy Environments and Consumer Safety Branch		
Dr. Jody Gomber, Director General, Drug Strategy and Controlled Substances Program, Healthy Environments and Consumer Safety Branch		
Correctional Service Canada		6
Julie Keravel, Director, Security Information and Emergency Management		
Ross Toller, Acting Director General, Offender Programs and Reintegration		
Royal Canadian Mounted Police		
R.G. Bob Lesser, Chief Superintendent, Officer in Charge, Drug Enforcement Branch, Federal Services Directorate		
Senate	18/10/2001	8
Blair Armitage, Clerk, Special Committee on Illegal Drugs		
The Hon. Pierre Claude Nolin, Senator, Chair, Special Committee on Illegal Drugs		
Dr. Daniel Sansfaçon, Director of Research, Special Committee on Illegal Drugs		

Associations and Individuals	Date	Meeting
Canadian Centre on Substance Abuse	25/10/2001	9
Dr. Colleen Anne Dell, National Research Advisor		
Michel Perron, Chief Executive Officer		
University of Toronto	07/11/2001	11
Dr. Eric Single, Professor of Public Health Sciences, Faculty of Medicine		
Department of the Solicitor General	08/11/2001	12
Karen Kastner, Senior Policy Analyst		
Paul E. Kennedy, Senior Assistant Deputy Solicitor General, Policing and Security Branch		
Canada Customs and Revenue Agency	21/11/2001	13
Angelo De Riggi, Intelligence Officer		
Royal Canadian Mounted Police		
Pierre Primeau, Investigator		
Montreal Urban Community Police Department		
Yvan Côté, Investigator		
Fraser Institute	03/12/2001	14
Fred McMahon, Director, Social Affairs Centre		
Kaiser Foundation		
Dan Reist, President		
Prevention Source B.C.		
Dr. Colin Mangham, Director		
Simon Fraser University		
Bruce Alexander, Professor, Department of Psychology		
University of British Columbia		
Dr. Michael O'Shaughnessy, Vice-President, Research, Director of the Centre for Excellence on HIV		
Dr. Martin Schechter, Head of Epidemiology and Biostatistics		
Dr. Julian Somers, Mental Health Evaluation and Community Consultation Unit, Department of Psychiatry, St. Paul's Hospital		
Dr. Mark Tyndall		
As an Individual		
Larry Campbell, Former Chief Coroner, BC		
Abbotsford Police Department		15
Ian Mackenzie, Chief Constable		

Associations and Individuals	Date	Meeting
Alcohol — Drug Education Services Art Steinmann, Executive Director	03/12/2001	15
Canada Customs and Revenue Agency Brian Flagel, Director, Customs Border Services, Vancouver International Airport District		
John Howard Society of the Lower Mainland Larry Howett, Spokesperson, CHOICES		
Organized Crime Agency of British Columbia Peter Ditchfield, Deputy Chief		
Pacifica Treatment Centre Kathy Oxner, Executive Director		
Royal Canadian Mounted Police Carl Busson, Superintendent, Officer in Charge, Drug Enforcement Branch Chuck Doucette, Staff Sergeant, Provincial Coordinator, Drug Awareness Service, "E" Division		
Seaview Addictions Services Society Donna Baird, Executive Director		
Vancouver Police Department Kash Heed, Commanding Officer, Vice/Drugs Section		
City of Vancouver Donald MacPherson, Drug Policy Coordinator, Social Planning Department	04/12/2001	16
International Drug Education and Awareness Society Linda Bentall, President		
Vancouver/Richmond Health Board Dr. Mark McLean, Associate Medical Health Officer		
As an Individual Joan Gadsby		
AIDS Vancouver Thomas Kerr, Health Researcher Warren O'Briain, Director, Community Development	05/12/2001	17
BC Persons with AIDS Society Naomi Brunemeyer, Director of Communications		
British Columbia Civil Liberties Association Lindsay Lyster, Policy Director		

Associations and Individuals	Date	Meeting
Downtown Eastside Youth Activities Society	05/12/2001	17
John Turvey, Executive Director, Street Services		
Life Is Not Enough Society		
Thia Walter, Family Member, Coordinator		
Vancouver Area Network of Drug Users		
Earl Crow, President		
Ann Livingston, Project Coordinator		
Dean Wilson		
Vancouver Board of Trade		
Dennis Farrell, Chair, Property Crime Task Force, Co-Chair, Downtown Eastside Task Force		
Glenn Young, Co-Chair, Downtown Eastside Task Force; President, International Tradewind Strategies, Inc.		
Abbotsford Addiction Centre	06/12/2001	18
Charlaine Avery, Clinical Director		
Abbotsford Detox Steering Committee		
Uultje De Jong		
Abbotsford Downtown Business Area		
Mary Reeves, Executive Director		
Abbotsford Police Victims Services		
Delaine Milette, Coordinator		
Abbotsford School Board District		
Joanne Field, Vice-Chair		
Des McKay, Principal, W.J. Movat Secondary School		
Campbell Valley Women's Centre		
Terri-Lee Seeley, Executive Director		
Cannabis Culture Magazine		
Dana Larsen, Editor		
City of Abbotsford		
George Ferguson, Mayor		
Full Circle Life Recovery Strategy		
Andy Rowe, Director		
National Training Centre		
John Parker, Director, Self-Protection and Functional Fitness		
Taking Back the Streets		
Diane Sowden		

Associations and Individuals	Date	Meeting
Wagner Hill Farms	06/12/2001	18
Helmut Boehm, Executive Director		
As Individuals		
Jamie Hamilton		
Marcyne Heinrichs		
Barry Neufeld, Abbotsford youth probation officer		
Les Talvio		
Office of the Auditor General	06/02/2002	20
David Brittain, Principal		
Michael McLaughlin, Deputy Auditor General		
Canadian Foundation for Drug Policy and Harm Reduction Network	18/02/2002	22
Dr. Diane Riley		
Centres for Addictions and Mental Health		
Dr. Patricia Erickson, Senior Scientist		
University of Toronto		
Dr. Peggy Millson, Department of Public Health Sciences		
Dr. Robert Remis, Associate Professor, Department of Public Health Sciences		
York University		
Alan Young, Associate Professor, Osgoode Hall Law School		
Centre for Addiction and Mental Health		23
Mike Naymark		
Department of Justice		
Croft Michaelson, Director and Senior General Counsel, Strategic Prosecution Policy Section		
Halton Regional Police Services		
Signy Pittman, Inspector		
Ontario Professional Fire Fighters Association		
George Birtig		
Henry Watson, President		
Queen East Business Association		
Hélène St. Jacques		
Margaret Steeves		
Royal Canadian Mounted Police		
Ron Allen, Inspector, Greater Toronto Area Drug Enforcement Unit		

Associations and Individuals	Date	Meeting
Toronto Drug Treatment Court	18/02/2002	23
Kofi Barnes, Senior Counsel		
Toronto East Downtown Neighbourhood Alliance		
Steve Bourgeois		
Madelyn Webb, Chair		
Toronto Police Services		
Courtland Booth, Detective, Central Drug Information Unit		
Julian Fantino, Chief		
Waterloo Regional Police Services		
Bill Stevens, Superintendent, Operational Support		
Matt Torigian, Inspector, Operational Support		
Canadian HIV-AIDS Legal Network	19/02/2002	24
Glenn Betteridge, Lawyer		
Centre for Addiction and Mental Health		
Dr. David Marsh		
Prisoners with HIV/AIDS Support Action Network		
Koshala Nallanayagam, Hep 'C' Co-ordinator		
Seaton House		
Toby Druce, Program Coordinator		
Chris Gibson, Program Supervisor		
The Canadian Harm Reduction Network		
Walter Cavalieri		
Breakaway	21/02/2002	25
Dennis Long, Executive Director		
Caritas		
Elio Sergnese, Director		
Illicit Drug Users Union of Toronto		
Raffi Balian, Co-founder		
Marc McKenzie, Assistant		
Operation Springboard		
Wanda McPherson, Diversion Office		
Remo Paglia		
Toronto Public Health		
Dr. Joyce Bernstein, Drug Prevention Centre		
Alcohol and Drug Recovery Association of Ontario		26
Jeff Wilbee, Executive Director		

Associations and Individuals	Date	Meeting
Bellwood Total Health Centre	21/02/2002	26
Linda Bell, President		
Mount Sinai Hospital Foundation of Toronto		
Dr. Douglas Gourlay, Pain and Chemical Dependency, Wasser Pain Management Centre		
Ontario Medical Association		
Dr. Frank Evans, Chair, Addictions Medicine Committee		
Salvation Army Harbour Light Centre		
Dean Tate, Program Coordinator		
The Jean Tweed Centre		
Nancy Usher, Executive Director		
Parliament of Westminster	26/02/2002	27
Paul Flynn, Labour, Newport West		
Department of Health	27/02/2002	28
Peter Cooney, Acting Director General, Non-Insured Health Benefits, First Nations and Inuit Health Branch		
Nick Hossack, Senior Manager, Addictions Team, First Nations and Inuit Health Branch		
Canadian Foundation for Drug Policy and Harm Reduction Network	28/02/2002	29
Eugene Oscapella, Executive Director		
University of Ottawa	11/03/2002	30
Line Beauchesne, Associate Professor, Department of Criminology		
Physicians for a Smoke-Free Canada	13/03/2002	31
Cynthia Callard, Executive Director		
Christy Ferguson, Researcher		
Dr. Jim Walker, Secretary-Treasurer		
Department of Health and Social Services of Prince Edward Island	15/04/2002	34
Maureen McIver, Provincial Addictions Consultant, Child, Family and Community Services		
Kevin McKinnon, Coordinator, Youth and Family Programs		
Royal Canadian Mounted Police		
Rick Gibbons, Sergeant, Joint Drug Enforcement		
Ken Murray, Corporal, Co-Chair, Hep “C” Committee		
Talbot House		
Wayne Clark, Director		

Associations and Individuals	Date	Meeting
Marijuana Party of Canada Mike Patriquen	16/04/2002	35
Memorial University of Newfoundland Dr. Robert Adamec, Professor of Psychology Dr. William McKim, Professor of Psychology		
AIDS New Brunswick Margaret Dykeman, President	17/04/2002	36
Dalhousie University Dr. Christiane Poulin, Associate Professor, Department of Community Health and Epidemiology		
Halifax Regional Police Drug Unit Rosco Larder, Sergeant		
Healing Our Nation Renée Masching, Executive Director		
Miramichi Police Force Mike Gallagher, Corporal, Supervisor, Drug Section		
RCMP Coastal Watch Programme Jim Skanes, Sergeant, "B" Division		
RCMP DAS Programme Peter Keirstead, Corporal, Halifax		
Royal Canadian Mounted Police Michel Frenette, Corporal, Drug Awareness Services Coordinator, Fredericton, N.B.		
SANE Sharp Advice Needle Exchange Howie Sullivan, Executive Director		
York County Court House Dianne Kelly, Chief Coroner, Province of New Brunswick		
Charles J. Andrew Restoration Centre John Graham, Executive Director	18/04/2002	37
Direction 180 Cindy MacIsaac, Program Director		
Nova Scotia Department of Health Shaun Black, Pharmacologist, Drug Dependency, Central Region		

Associations and Individuals	Date	Meeting
Ontario Provincial Police	22/04/2002	38
Rick Barnum, Detective Superintendent		
Gwen Boniface, Commissioner		
Morris Elbers, Detective Superintendent		
Jim Hutchinson, Detective Superintendent		
Federation of Canadian Municipalities	24/04/2002	39
Bill Marra, Councillor; Chair, FCM's Standing Committee on Community Safety and Crime Prevention		
Janet Neves, Policy Analyst		
As an Individual	25/04/2002	40
Dr. Keith Martin, M.P., Esquimalt—Juan de Fuca		
Canadian Association of Chiefs of Police	08/05/2002	42
Michael Boyd, Deputy Chief, Toronto Police Services, Chair, Drug Abuse Committee		
Jim Hutchinson, Detective Superintendent, Ontario Provincial Police		
Michel Pelletier, Staff Sergeant, National Coordinator, Drug Awareness Service		
Canadian Police Association		
Glen Hayden, Former Drug Investigator with Edmonton Police Service and CPA Vice-President		
Mike Niebudek, Vice-President		
Alberta Alcohol and Drug Abuse Commission	21/05/2002	43
Ed Sawka, Director, Research Studies		
Capital Health Authority		
Dr. Marcia Johnson, Deputy Medical Officer of Health		
Royal Canadian Mounted Police		
Doug Carruthers, Staff Sergeant		
Jim Jancsek, Corporal		
University of Alberta		
Cameron Wild, Professor, Centre for Health Promotion Studies		
Alberta Alcohol and Drug Abuse Commission	22/05/2002	44
Howard Faulkner, Executive Director, Prevention/Treatment Services		
Kathy Landry, Manager, AADAC Northern Addiction Centre		
Beth Lipsett, Manager, Adult Counselling and Prevention Services		

Associations and Individuals	Date	Meeting
Aventa	22/05/2002	44
Cathy Wood, Manager		
Boyle Street Co-op		
Faye Dewar, Street Reach Worker		
DARE Evaluation Committee of Alberta		
Debra Williams, Chair		
HIV Edmonton		
Deborah Foster, Program Manager		
Kate Gunn, Interim Director		
St. Albert Association for People with Disabilities		
Julie-Ann Miller, PARTY Coordinator		
Streetworks		
Marliss Taylor, Manager		
Métis Indian Town Alcohol Association		45
Doug Bellerose, Executive Director		
Native Addictions Services Society		
Shawn Meier, Program Manager		
Native Counselling Services of Alberta		
Allen Benson, Chief Executive Officer		
Rocky Mountain House Native Friendship Centre		
Ellen Sanderson		
Faith Alive Ministries	23/05/2002	46
Rev. Ross Powell		
Regina Health District		
Lyell Armitage, Former Director, Alcohol and Drug Services		
Saskatoon District Health		
Sandra Lane, Primary Prevention Worker, Addictions Services		
White Buffalo Youth Lodge		
Gary Beaudin, Executive Director		
Addictions Services — Outpatient		47
Ernie How, Coordinator		
Calder Centre		
Blair Buchholz, Manager, Youth Services		
Larson House		
Bill Logue, Director		

Associations and Individuals	Date	Meeting
Addictions Foundation of Manitoba	24/05/2002	48
Dr. David Brown, Director of Research and Quality Monitoring		
Royal Canadian Mounted Policy		
William Blanshard, Sergeant, Drug Awareness, "F" Division		
Cory Lerat, Sergeant, Prince Albert Joint Forces Unit, "F" Division		
Rick Torgunrud, Sergeant, Prince Albert Joint Forces Unit, "F" Division		
Keith Van Steelandt, Corporal, Prince Albert Joint Forces Unit, "F" Division		
Saskatoon City Police		
Brian Dueck, Superintendent, Human Resources		
Jerome Engele, Sergeant, Saskatoon Integrated Drug Unit		
Western Safety and Disability Management		
H. Alex Taylor		
Winnipeg Police Services		
Blair McCorrister		
Association for Better Living and Education (ABLE Canada)	30/05/2002	49
Brad Melnychuk, Executive Director		
Narconon		
Devinder Luthra		
REAL Women of Canada		
Sophie Joannou, Executive Member		
Gwendolyn Landolt, National Vice-President		
Diane Watts, Researcher		
Carleton University	10/06/2002	50
Dr. Peter Fried, Faculty of Psychology		
University of Manitoba		
Barney Sneiderman, Professor, Faculty of Law		
"Centre de réadaptation Le Portage"	13/06/2002	51
Dr. Peter Vamos, Director		
"Groupe de recherche et d'intervention psychosociale de Montréal"		
Jean-Sébastien Fallu		
McGill University		
Dr. Mark Zoccolillo, Associate Professor of Psychiatry and Assistant Professor of Pediatrics		

Associations and Individuals	Date	Meeting
As an Individual	13/06/2002	51
Dr. Carole Morissette, Community Health Specialist		
Canadian Pharmacists Association	27/08/2002	52
Dr. Barry Power, PharmD, Director of Practice Development		
Shelley Stepanuik, Vice-President		
National Association of Pharmacy Regulatory Authorities		
Jeff May, Past President		
Barbara Wells, Executive Director		
Purdue Pharma		
Andrew Darke, PhD, Vice-President, Scientific Affairs		
Kathryn Raymond, Manager, Health and Education		
Dr. Roman Jovey, M.D.		
Department of Foreign Affairs and International Trade		53
Terry Cormier, Director, International Crime Division		
Nonprescription Drug Manufacturers Association of Canada		
Gerry Harrington, Director, Public and Professional Affairs		
Robert White, Director, Scientific and Regulatory Affairs		
Department of Health	28/08/2002	54
Carole Bouchard, Director, Office of Controlled Substances		
Dr. Gillian Lynch, Director General, Drug Strategy and Controlled Substances Program, Healthy Environments and Consumer Safety Branch		
Dann Michols, Assistant Deputy Minister, Healthy Environments and Consumer Safety Branch		
Beth Pieterson, Associate Director General, Drug Strategy and Controlled Substances Program, Healthy Environments and Consumer Safety Branch		
College of Physicians and Surgeons of British Columbia		55
Peter Hickey, Pharmacist		
Dr. Brian Taylor, M.D.		
College of Physicians and Surgeons of Saskatchewan		
Dr. Dennis Kendel, M.D., Registrar		
Nova Scotia Prescription Monitoring Program		
Coleen Conway, Manager		

Associations and Individuals	Date	Meeting
Canadian Executive Council on Addictions	29/08/2002	56
John Borody, Chief Executive Officer, Addictions Foundation of Manitoba		
Murray Finnerty, Chief Executive Officer, Alberta Alcohol and Drug Abuse Commission		
Michel Perron, Chief Executive Officer and President of CECA, Canadian Centre on Substance Abuse		
Patrick Smith, Executive Vice-President, Centre for Addictions and Mental Health		

APPENDIX D
LIST OF BRIEFS

Abbotsford Addictions Centre
Addiction Intervention Association
Addictions Foundation of Manitoba
Addictions Services — Outpatient
AIDS New Brunswick
AIDS Vancouver
Alberta Alcohol and Drug Abuse Commission
Alberta Health
Alcohol-Drug Education Service
Alcohol and Drug Recovery Association of Ontario
Battlefords Health District
BC Hepatitis C Collaborative Circle
Bellwood Health Services
Dave Burkhart
Calder Centre
Canada Customs and Revenue Agency
Canadian Association of Chiefs of Police
Canadian Centre on Substance Abuse
Canadian Executive Council on Addictions
Canadian Foundation for Drug Policy and Harm Reduction Network
Canadian HIV-AIDS Legal Network
Canadian Medical Association
Canadian Pharmacists Association
Canadian Police Association
Capital Health Authority
Caritas
Carleton University
Centre for Addictions and Mental Health
Charles J. Andrew Youth Treatment Centre

College of Physicians and Surgeons of Saskatchewan
DARE Evaluation Committee of Alberta
Department of Health — New Brunswick
Department of Health — Saskatchewan
Department of Health and Social Services of Prince Edward Island
Department of the Solicitor General
Chris Donald
John Dorst
Downtown Eastside Youth Activities Society
Drug Treatment Court of Toronto
Matthew Elrod
Michel Ethier
James Fanning
Federation of Canadian Municipalities
Sam Fedyk
Paul Flynn, M.P., Labour, Newport West, Parliament of Westminster
"Forum Action-Toxico"
From Grief to Action
Joan Gadsby
Chris Goodwin
Halifax Regional Police Drug Unit
Neil Halliday
Halton Regional Police Services
Debra Harper
Patrick Hauser
Healing Our Nations
Health Canada
Marcyne Heinrichs
B. Horsfall
Illicit Drug Users Union of Toronto
International Drug Education & Awareness Society
Nancy Irwin
Jarvis Street Harbour Light Centre

John Howard Society of the Lower Mainland
John Innes Advisory Council
Kaiser Foundation
Joseph Leger
Anthony Lewis
Life Is Not Enough Society
Lower Mainland Municipal Association
Neil MacNaughton
Manitoba Provincial Health Programs
Marijuana Party of Canada
Richard Mathias
McGill University
Memorial University of Newfoundland
Brian Metcalfe
Miramichi Police Force
National Council of Women of Canada
National Training Centre
Eileen Nattrass
Nova Scotia Department of Health
Nova Scotia Prescription Monitoring Programme
Novartis Pharma Canada Inc.
Ontario Medical Association
Ontario Professional Fire Fighters Association
Ontario Provincial Police
Operation Springboard
Organized Crime Agency of British Columbia
Pacifica Treatment Centre
Parkdale Pharmacy (1981) Ltd.
Peak House
Erich & Elsie Penner
Wayne Phillips
Prisoners with HIV/AIDS Support Action Network
Purdue Pharma

Diana Quast
Queen's University
RCMP Coastal Watch Programme
REAL Women of Canada
Renascent Centre
Rocky Mountain House Native Friendship Centre
Susan Rogan
Royal Canadian Mounted Police
Adam Scriven
Sharon Shier
Simon Fraser University
Lorraine Smith
Derek Spencer
Lila Stanford
Streetworks
Debbie Stultz-Giffin
Kathy Thiessen
Toronto East Downtown Neighbourhood Alliance
Toronto Police Services
University of Alberta
University of British Columbia
University of Manitoba
University of Ottawa
University of Toronto
Vancouver Board of Trade
Vancouver Coastal Health Authority
Vancouver/Richmond Health Board
Wagner Hills Farm Society
Wasser Pain Centre
Mary White
Elizabeth Woods
John Yearsley

TOWN HALL MEETINGS

Mac Harb, M.P., Ottawa Centre, Ontario

Werner Schmidt, M.P., Kelowna, British Columbia

Carol Skelton, M.P., Saskatoon—Rosetown—Biggar, Saskatchewan

REQUEST FOR GOVERNMENT RESPONSE

Pursuant to Standing Order 109, the Committee requests that the government table a comprehensive response to this report.

A copy of the relevant Minutes of Proceedings (*Meetings Nos. 1 to 19 including the present report)* is tabled.

Respectfully submitted,

Paddy Torsney, M.P.
Chair

A SUPPLEMENTARY REPORT FROM THE OFFICIAL OPPOSITION

We brought a motion into the House of Commons on May 17, 2001 that was unanimously adopted by all parties. This motion enabled Parliament to study " the factors underlying or relating to non-medical use of drugs in Canada." We had sincerely hoped that our country would benefit from a thorough and unbiased study since one hasn't occurred since 1972; it was well overdue.

We have been impressed with the attentiveness to the matter by a majority of members of the committee (with the notable exception being the member of the Progressive Conservative party who only briefly attended three of our meetings in Ottawa, and none of our site visits across the country or abroad), however we are concerned with some of the final recommendations to the issue. Consequently we are submitting this supplementary report in order that our apprehension concerning a proposed National Drug Strategy, or lack thereof, is made known.

First, we are quite appalled that the Government has disregarded the fact that we have spent almost $500,000 studying drugs on this committee as well as undergoing cross-country consultations on this issue for the past 18 months. Unfortunately, no less than three ministers have established policy directions without once consulting us. Let us quote just some of their statements...

> "Canada's pot laws make no sense and should be liberalized"
> Justice minister Martin Cauchon, Toronto Star, Sept. 2002

> "We're in the process, Ms Mohamed said. "The minister, by the end of this year, will be able to accept proposals (for safe injection sites)"
> Farah Mohamed, spokesperson for Health Minister
> Anne McLellan, Saint John Telegraph Journal, Nov. 2002

> "We will do everything we can to facilitate pilots in cities across the country if those cities decide this is part of the strategy that they want"
> Allan Rock, Federal Health Minister, National Post, Nov. 2001

These ministers have inappropriately pre-empted the committees' report. It is interesting to note that the very departments [Health Canada and Justice/Solicitor General] that are giving advice to these ministers are the worst performing departments in the country as far as efficiency and effectiveness towards a National Drug Strategy. This fact is born out of the committees' research.

Now we see the Liberal Health minister is promoting both safe shoot up sites and heroin maintenance programs that will supplement needle exchanges, yet she will not even provide diabetics with free needles. One wonders how "Heroin Maintenance Treatment" trials, set to be undertaken in Vancouver, Toronto and Montreal, which is assisting an individual to shoot drugs into themselves, is in any way solving the problem? If the Minister had taken the time to wait for the results from the committee, we are confident it would have offered her a more balanced view of the issue that her department is providing. Encouraging and supporting addicts to use needles to shoot drugs into themselves is nothing short of aiding in the death of another human and a reprehensible action of a government Minister to endorse that action, in particular without even asking the government's special committee its position.

Inherent in the committees' report is the issue and acceptance of the idea of "harm reduction". We would more appropriately call this "harm extension", a description that has been confirmed by numerous witnesses over the past 18 months. "Harm reduction" by its very nature dismisses the basic premise that substance abuse is effectively treated through abstinence, detox and rehabilitation and essentially says, "We give up, let's encourage use — but make it clean use ". We clearly understand that the debate on this issue of abstinence and harm reduction will go on for some time yet, however; it is incumbent upon those of us in Canada who are concerned with the concept of "harm reduction" to express it.

It is vital that those reading this report understand the issue of "Pilot Projects" as the Health Minister has begun to undertake. The following quote was written down by Randy White, at the time of a meeting of the committee in Frankfurt, Germany .....

> " the vision of legalization of drugs must be taken one pilot project at a time — not all at once"
>
> Dr. Korner
> Prosecuter from the State of Hesse's General Prosecutor's office
> 10:42 AM, Wednesday, June 19, 2002, Frankfurt, Germany

This, to us, needs no further comment.

There is no commitment requested or contained in this report to encourage the building or enhancement of rehabilitation centers with or without residence. If a pilot project is good enough for safe injection sites or heroin maintenance, then why not a pilot project to develop Detox and Rehabilitation Centers? Indeed there is a substantial denial of responsibility at all three levels of government. It is impractical to move toward some concept called "harm reduction" before such a commitment towards detox and rehabilitation is made and proven not to work.

Recommendation 15, in the report, is one of those issues that looks quite simple when you first look at it. The concept of "low threshold" means ask no questions — just accommodate. Let's look at a common case. An addict walks into a safe shoot up site with bad drugs [impure and more lethal than normal] and no one asks questions. The results are potentially lethal, no contact is made with medical people and the person is essentially on their own. We do not see this as a responsible position and cannot be supported.

Recommendation 19, of the report, is another of those issues that asks the question of what, in the future, is "substitution treatment"? To date we would acknowledge that methadone is an alternative treatment even though many say it also is very addictive. The fact that it is able to be consumed by drink and not injected by needles seems to be its saving grace. The fact remains that we want assurances that "substitutes" in the term substitution treatment are well researched, socially and medically acceptable and not a continuation of "harm extension" before we concur with an open ended recommendation. We in Canada must consider the position of those who say the provision of "prescribed heroin" would be considered a "substitute for "on the street heroin".

Recommendation 20 is particularly troubling. Proposed projects for heroin-assisted treatment isn't even "substitution treatment". These projects advocate legally permitting heroin being injected into people, which is a concept we cannot concur with.

Recommendations 21 and 23 suggest removing legislative barriers which is to really say that we will remove the laws that stop the open drug trade that exists, in fact, what it does is make the hard drug trade legal. Police must turn their back to possession which is currently against the law. How can we put addicts above the law? It will be all too soon when individuals and groups in other parts of the country will be challenging, in court, their right to shoot up in various places they call "safe" because others inject legally elsewhere thus, the beginning of legalized drugs as Dr. Korner predicts.

Recommendation 31 is a preposterous recommendation. We cannot permit inmates to have access to needles, through needle exchanges simply because it is dangerous for guards and for other inmates as well. How does this fit into the concept of "zero" tolerance for drugs in prison? If any place in Canada should practice abstinence it should be the prison system. Other methods of substitutes or "harm reduction" cannot include needle exchanges, heroin maintenance or safe injection in prison.

Many of the issues reflected in this supplementary report will affect the border relationship with the United States and although we are our own country, we should not put harmful social policy in place before we discuss it with our neighbor. This concept of "harm reduction" will lead to a "magnet" approach to those areas who have safe injection sites and will encourage addicted Americans and others to relocate to Canada as has happened in Europe. We currently have a refugee application in Canada from an individual claiming to avoid "persecution" [not prosecution] from American drug laws. We do not need American concurrence but we do need their co-operation.

We had also wanted the main theme of the document to state that "ABSTINENCE IS THE BEST POLICY" however, the committee majority did not want that. We believe that parents, addicts and responsible citizens around the world would agree to this statement and wonder why anyone on the committee would want otherwise.

In conclusion, we believe this committee has worked together in a positive manner and that most of the recommendations contained in this report will begin to make positive changes in regards to the ongoing drug problem in this country. A viable framework now exists to create a National Drug Strategy that will have its greatest effect at street level, however ……

We are extremely concerned that the Liberal government has already adopted the "harm reduction" model of Europe which is proving to be a failure (because it maintains drug addicts on drugs) while at the same time ignoring our north American partners of the United States and Mexico who are moving in significant directions of intervention, education, rehabilitation and treatment based upon abstinence. Canada does this at it's own social peril.

It must be remembered this report on the national drug problem is not the recommendations of one stakeholder, or even 13 Members of Parliament. These are the combined voices of thousands of victims, enforcement officers, drug users, social workers and health care professionals, collected in hundreds of meetings across the country — as well as in the United States and Europe. We urge this government to listen the voices of those who are effected daily by this problem, and make the changes necessary to create a truly effective National Drug Strategy.

R.A. White, M.P.
Langley—Abbotsford

K. Sorenson, M.P.
Crowfoot

A SUPPLEMENTARY REPORT FROM THE OFFICIAL OPPOSITION

MARIJUANA

The issue of marijuana use has not been addressed in the detail that the Senate covered, since the Senate report focused exclusively on cannabis, thus the decision rendered by this committee will be more political than practical. We could agree that minor possession should be a summary conviction [a fine] provided the fine is attached to something that would force payment [like a driver's license] and that the proceeds of the fines be dedicated to drug education. No recommendation has been made concerning fines therefore this is legalization. It also has to be clearly understood that possession is illegal and this is not a green light for use nor is it a green light to grow.

Smoking marijuana is harmful, illegal and selling or growing it must remain a criminal offense. Drug driving laws must also be implemented and enforced and dealt with reasonably and effectively in the courts. It is impractical to spend millions each year advertising the bad effects of cigarettes then loosen the reigns on marijuana.

Before decriminalization takes place the issues identified above must be dealt with including the issue of how much minor possession is. How anyone could recommend 30 grams of marijuana be decriminalized and not say they are legalizing it is a mystery. Even Holland, the most Liberal of all countries only accepts 5 grams as the maximum amount. The committee is disguising its motives and is legalizing marijuana not just to posses but to grow. How does anyone determine 30 grams growing in any number of plants?

This recommendation is irresponsible and only serves to support the Liberal cabinet's objectives.

SUPPLEMENTARY OPINION

BY THE BLOC QUEBECOIS

SPECIAL COMMITTEE

ON THE NON-MEDICAL USE OF DRUGS

> *The Bloc Quebecois would like to make a few observations in this supplementary opinion in order to clarify its views on the use of non-medical drugs.*

The Bloc Quebecois MPs who participated in the Committee's deliberations do not contest the great importance of the use of drugs and the problems of drug addiction. Drug addiction destroys lives, weakens families and poisons communities. It is responsible for suffering among children, parental anxiety, violence among certain individuals who become involved in organized crime and a loss of productivity on the part of those unable to do an honest day's work, among other things. The Bloc Quebecois is well aware that all levels of government are concerned about the use of drugs. The Bloc Quebecois therefore supports the broad lines of the present report.

It would, however, like to reaffirm the fact that, while all are concerned by the problem of drugs, the provincial governments alone have constitutional jurisdiction to deliver health care to the public. While the federal government may claim this jurisdiction in the case of Native Peoples, penitentiary inmates and members of the Canadian armed forces, it is clear that, for the Bloc MPs, a new federal anti-drug strategy is to be implemented within these parameters.

A number of proposals in the present report concern the availability of care, the provision of treatment, needle exchanges and public health policies. It seems to us, with regard to these questions, that, while the federal government can indicate it would like a given province to take a certain approach, in the end, the provincial governments themselves will decide on the type of policy to adopt.

In short, the Bloc Québécois cannot agree to some future federal anti-drug policy being a factor in the definition of a single health care system in which the federal government, drawing on the recommendations of the National Forum on Health (1997), the Kirby report

(2000-2002) or the Romanow Commission, interferes in the health care sector in areas from early childhood to palliative care. Especially since, from 1994 to date the federal government has cut $35 billion in health transfer payments to the provinces.

In addition to the jurisdictional matters we have mentioned, Bloc Quebecois support for a drug use intervention framework will depend on the acceptance of the following two principles:

1. Application of the harm reduction strategy

For twenty years now, this intervention approach, which originated in Great Britain, has been a component of the Government of Quebec's public policies on drugs. It provides that, while abstinence may certainly be the ideal, it may not be a realistic objective in all cases. It is better to ensure that drug addicts use drugs in safe conditions, first, and steps leading to abstinence may then be proposed.

2. Reworking of the legislative framework

The Bloc Québécois believes that Chapter 9 on marijuana is the report's weakest chapter. It cannot be overemphasized that 80 years of marijuana prohibition have not led to the achievement of the objectives set in public health and in the fight against organized crime.

The current legislative framework has contributed significantly to the emergence of a substantial illicit drug trade. The Auditor General of Canada estimated the illicit drug market's sales in Canada at between $7 billion and $18 billion in 2000. It would appear that only 10% of the drugs circulating in Canada are seized by law enforcement agencies.

It is clear to the Bloc Quebecois that the criminal process currently in place for the simple possession of marijuana is outdated and retrograde. No one should end up with a police record simply for possessing cannabis. The list of difficulties caused by the establishment of a police record is long and includes denial of bail and problems clearing customs, obtaining citizenship and obtaining employment, etc. In this regard, the Bloc Quebecois fully supports recommendations 40 and 41, which refers to a comprehensive strategy for decriminalizing the possession of marijuana for personal use.

The Bloc Quebecois would also like to see some of the money from drug seizures allocated to public awareness and education programs. In addition, the Bloc Quebecois believes that the unstable and changing nature of organized crime combined with the fact that a number of test cases are currently before the courts, fully justifies having a committee of the House report on the various laws passed in the matter and develop recommendations to bring the Criminal Code more in line with the state of the underworld of the 2000s.

Bloc Quebecois MPs, like their colleagues, worked hard in committee deliberations and heard over 200 witnesses, read thousands of pages of expert opinions and travelled to major Canadian cities such as: Montreal, Ottawa, Vancouver, Toronto, Charlottetown, Halifax, Edmonton and Saskatoon. At the end of this work, we state in no uncertain terms that it would be a grave error, as are suggesting an element of the left in English Canada, the Nolin committee and parts of the present report, for the federal government to feel the need to head the fight against drug addiction and use.

First, it has been shown that the federal government managed its own anti-drug strategy between 1987 and 1998 very badly. In addition, the broad interventions required in the planning and development of an anti-drug policy are more closely associated with the education, treatment and development of awareness of marginalized clientele, areas all under provincial jurisdiction. This is very clear from an examination of the $104 million that Health Canada spends annually on drug addiction, which reveals that only $14 million of this figure is allocated to treatment and rehabilitation, and this money goes to the provinces. In short, of all the levels of government, the federal government has the least expertise in matters of drug addiction, except in the case of Native Peoples, penitentiaries and the Canadian armed forces.

SUPPLEMENTARY REPORT

LIBBY DAVIES MP VANCOUVER EAST

SPECIAL COMMITTEE ON THE NON-MEDICAL USE OF DRUGS

The NDP participated fully in the Special Committee on the Non-Medical Use of Drugs. Substance misuse in our society imports substantial social, economic and health costs for Canadians. The work of the Committee provided an important opportunity to examine substance misuse, and to hear from Canadians who are affected by this issue. The Committee members collaborated with each other and were respectful of divergent opinions. It is significant that many areas of agreement were found, and in this respect I wish to thank other members who worked so hard to achieve consensus on many issues.

The NDP supports many of the Committee's recommendations concerning education, prevention, treatment, harm-reduction and public safety. The NDP strongly supports the recommendations on the appointment of a Canadian Drug Commissioner with full powers to monitor, investigate and audit Canada's Drug Strategy. However, the appointment of such a Commissioner must reflect the philosophy that drug misuse is primarily a health issue, not an enforcement issue.

The NDP's main points of departure flow from the failure of the report to deal adequately with the fundamental harms caused by Canada's drug laws and federal government inaction. The lack of leadership by the federal government has had devastating health consequences in communities that are facing this crisis. Leadership on this issue has come from local communities as evidenced by the recent Vancouver municipal election. The federal government and Health Canada have been slow to act in responding to this health crisis. With so many lives lost it is shameful that it has taken so long for any substantive changes to take place as recommended by numerous experts.

The NDP generally supports recommendations 1 to 27 dealing with the mandate, role and priority for Canada's Drug Strategy, as well as recommendations concerning the need for accessible treatment from low threshold to long term recovery and support care and services. The NDP also believes strongly that clinical heroin trials and the establishment of safe consumption sites (recommendations 20 and 23) are urgently needed. In this regard Health Canada must act quickly to stop the needless waste of human life and social destruction in communities like the Downtown Eastside in Vancouver. The response needed must include both economic and legislative support for such consumption sites.

Focus on enforcement: The 2001 Auditor General's report on Illicit Drugs sharply focused on the weakness, lack of accountability and failed implementation of Canada's Drug Strategy. The primary focus of that strategy *in practice* has been on enforcement — the use of what are essentially criminal law powers to deal with drugs. This focus on interdiction ("supply reduction") has drawn resources away from other measures that could be far more effective in reducing substance misuse and its related harms.

The emphasis on criminal prosecution for behaviour linked to illicit drug use has not decreased use nor effectively dealt with serious health and safety issues. In fact, there is substantial expert evidence that prohibitionist policies and criminalization of drug users *increases* the harms associated with drugs. Drugs lack quality controls, education may be skewed because of the illegal status of drugs, and the expense of buying drugs on the illegal market may encourage users to take drugs in a manner that increases health risks. This greatly increases the risk of harm from disease and overdose. The report fails to distinguish harms that may flow from the pharmacology of the drug from harms that may flow from the policies, such as prohibition and inadequate education.

Drug education: The report acknowledges the need for drug education, but it downplays or misses two fundamental points. First, if drug misuse is a public health issue, why do the police deliver drug education programs? The police are qualified to discuss the law concerning illegal and legal drugs, but they are not pharmacologists or public health officials. There is substantial evidence that current drug education programs conducted by the police are ineffective.

Even if these flaws in current drug education programs did not exist, the police are constrained in the type of education they can give. Their job is to enforce the law. Some police may object to providing education on safe use practices, since they may view that as contradicting their role in enforcing the law against users. Yet by failing to provide education about how to use as safely as possible we abandon the many millions of Canadians who at some point use illegal drugs. While it is essential to discourage Canadians from harmful drug use, it is equally important to minimize the dangers for those who do, by giving honest, factual and non-judgmental education. Such education can save lives and protect the health of both users and the communities around them. There is a critical need for heath-based, realistic education and prevention, targeted to key groups who are at risk, such as youth, that promotes safety, health and well-being of individuals and the community as a whole.

The ineffectiveness of law enforcement: Law enforcement efforts have almost completely failed to stop the flow of illicit drugs into Canada. A Canada Customs and Revenue Agency witness who appeared before the committee in October 2001 suggested that Canada stops only about 10% of the drugs destined for our country. Cannabis and synthetic drugs are also produced domestically. Yet the overwhelming share of federal funds directed at drug issues in Canada go to law enforcement, according to the Auditor General. Even if law enforcement were able to greatly increase the percentage of drugs it seizes — say, to 50% of those entering Canada or produced in this country — it would come nowhere near to solving the problem. Drug prices would almost certainly rise, leading dependent users to commit "acquisitive" crimes to pay the inflated price. Users might also shift to other, less expensive and possibly more dangerous alternatives. And organized crime would continue to reap enormous profits from the illegal trade. This is not intended to be a criticism of the police (except to the extent that they might advocate continuing such failed measures), since the inherent dynamics of prohibition make their task impossible. If we cannot keep drugs out of Canada's prisons, why do we pretend that law enforcement can work in the much more open environment outside prisons?

The NDP therefore has serious reservations with recommendations 36-39. They relate to supply reduction, and leave as open ended what resources or additional powers are allocated to interdiction efforts. This section of the Report (Chapter 6) fails to come to terms with some of the serious underlying problems with Canada's Drug Strategy. To say that "more resources," particularly more law enforcement resources, will solve our drug problems is unrealistic and short sighted.

The financing of organized crime: The Committee seemed reluctant to analyse the connections between drug prohibition and organized crime. The NDP believes this required a detailed analysis and discussion for better public understanding about what public policy options exist. It is regrettable that the report basically ignores these key questions other than through a simple statement dismissing the organized crime issue. The diversion of hundreds of billions of dollars annually to criminal elements deserves more attention in the report than it has been given.

Governments around the world are looking for means to stem the flow of money to criminal elements, often calling for measures that severely threaten the civil liberties of their citizens, with little consequential benefit. Yet they often overlook how our current drug laws create the environment of such an enormously lucrative illegal market. It is important to not only consider the impact of these policies in Canada, but also globally, for example in countries like Colombia, where the pursuit of prohibitionist policies has caused suffering and violence. Discussing openly and honestly how prohibition creates a flow of money to such groups is absolutely vital.

Drug courts: The NDP has concerns about "drug courts." Drug courts have become a popular political solution to drug problems, but as yet there is no firm evidence that they are effective, or that the coercive treatment models they involve are successful. Resources could better be used to prevent those dealing with addiction, from ending up in the criminal justice system, in the first place. Therefore, the NDP has strong reservations about recommendations 28 and 29. The NDP also questions the viability of recommendations concerning Correctional Services Canada that promote abstinence as its overriding treatment objective (recommendation 33), and a three year plan to reduce substantially the flow of illicit drugs into prisons (recommendation 30). These recommendations fail to deal with the reality of drugs in our prisons. The NDP would place greater emphasis on adopting harm reducing measures, such as needle exchanges and widespread access to treatment, as a more practical solution. The NDP believes that recommendation 34 (establishment of two drug-free facilities for offenders) is contradictory, counter-productive and discriminatory to the need for adequate treatment services being made available to all offenders, as outlined in recommendation 35.

Marijuana: The Committee has recommended a version of decriminalization (recommendations 40 and 41). The NDP sees decriminalization as only a partial solution. Decriminalization of possession and cultivation of small amounts, as recommended by the Committee, would prevent such users and cultivators from receiving a criminal record. However, it still leaves intact the other harms associated with our current system of criminal prohibition. Among them, simply handing a "joint" to a friend would continue to constitute the offence of "trafficking" under the *Controlled Drugs and Substances Act*. The intrusive police powers given by the Act would likely remain.

Furthermore, the Committee's proposal does nothing to address the situation of those saddled with a criminal record for simple possession or for transfer or cultivation of small amounts for non-commercial purposes. If we accept that Canadians should not in future receive a criminal record for certain acts relating to marijuana, those convicted in the past should be pardoned under a general amnesty, and their records erased.

There has already been extensive public debate on the use of marijuana, decriminalization, and legalization. The NDP appreciates the Senate Special Committee Report on Cannabis that raises rational and significant questions. The federal government should consider their analysis and recommendation for a criminal exemption scheme. The NDP urges the federal government to investigate and introduce non-criminal and non-punitive regulatory approaches for adult use, as a preferable direction of public policy, emphasising the need for realistic education and harm prevention programs.

Medical marijuana: The Special Committee on the Non-Medical Use of Drugs did not deal with marijuana for medical use. However, the NDP wishes to draw attention to the serious problems and flaws in the federal government's medical marijuana program. The current regulations of the program are very restrictive, overly bureaucratic, and severely limit access by Canadians who have a legitimate need for therapeutic marijuana. The NDP believes that these unnecessary restrictions should be lifted. The recommendations of the Senate Special Committee on Illegal Drugs in this regard makes good sense, and should be adopted.

MINUTES OF PROCEEDINGS

Tuesday, November 19, 2002
(*Meeting No. 19*)

The Special Committee on Non-Medical Use of Drugs met *in camera* at 4:15 p.m. this day, in Room 701, La Promenade Building, the Chair, Paddy Torsney, presiding.

Members of the Committee present: Carole-Marie Allard, the Hon. Hedy Fry, Derek Lee, Réal Ménard, Kevin Sorenson and Paddy Torsney.

Acting Members present: Beth Phinney for Mac Harb; Roger Cuzner for Jacques Saada.

In attendance: *From the Library of Parliament*: Chantal Collin and Marilyn Pilon, research officers.

Pursuant to the Order of Reference adopted by the House of Commons on Monday, October 7, 2002, consideration of the factors underlying or relating to the non-medical use of drugs.

The Committee resumed consideration of its draft report.

It was agreed, on division — That the Committee adopt the draft report as its report to the House of Commons.

It was agreed, — That the Chair be authorized to make such typographical and editorial changes as may be necessary without changing the substance of the report.

It was agreed, on division — That the Chair be authorized to engage the services of a media relations consultant to develop a communications strategy for the release of the report and, that the contract be limited to a maximum of $10,000. The proposal to be discussed at a meeting of the Special Committee scheduled for Tuesday, November 26, 2002.

It was agreed, on division — That pursuant to Standing Order 109, the Committee requests that the Government table a comprehensive response to this report.

At 7:08 p.m., the Committee adjourned to the call of the Chair.

Tuesday, November 26, 2002
(*Meeting No. 20*)

The Special Committee on Non-Medical Use of Drugs met *in camera* at 9:15 a.m. this day, in Room 306, West Block, the Chair, Paddy Torsney, presiding.

Members of the Committee present: Carole-Marie Allard, Hedy Fry, Mac Harb, Dominic LeBlanc, Derek Lee, Réal Ménard, Kevin Sorenson, Paddy Torsney and Randy White.

In attendance: *From the Library of Parliament*: Chantal Collin and Marilyn Pilon, research officers.

Witnesses: *From Hill & Knowlton Canada*: Heidi Bonnell, Vice-President Communications; Joy Jennissen, Vice-President.

Pursuant to the Order of Reference adopted by the House of Commons on Monday, October 7, 2002, consideration of the factors underlying or relating to the non-medical use of drugs.

The witnesses made a presentation on a communications strategy for the release of the Committee's report.

It was agreed, — That the Committee present its recommendations in two reports, an interim report to be presented on Monday, December 9, 2002, the final report on Thursday, December 12, 2002 and, that the Committee hold simultaneous press conferences in locations across Canada.

It was agreed, — That the Committee seek authorization of the House of Commons permitting the members of the Committee to travel to Vancouver, Halifax and Montreal to hold simultaneous press conferences on the release of its interim report on Monday, December 9 and that the necessary staff accompany the members.

It was agreed, on division, — That not withstanding the motion adopted at its meeting of Tuesday, November 19th, the Chair, in consultation with the two Vice-Chairs, be authorized to renegotiate a contract with Hill & Knowlton Canada to implement a communications strategy for the Committee's reports to a maximum of $15,000.

At 10:58 a.m., the Committee adjourned to the call of the Chair.

Carol Chafe
Clerk of the Committee

Strong family ties seen deterrent to drug use

CALGARY — Focus on the Family has launched a program

About 160 people attended a Tuesday night session
organization.

"Focus on the Family is launching this education
empower parents and give them the skills they'll need
tive of the organization.

The program, How to Drug Proof Your Kids,

It's based on recruiting parents to become
other parents.

So far, more than 700 programs have been

About 1,200 community facilitators have been

The program consists of six sessions,
two hours.

The sessions cover areas such as why kids
good choices, prevention tools for parents and

Webber cited studies from Statistics Can
to prevent children from falling prey to drug

He said half of youngsters who say they
than any other influence.

Webber explained teens who experience
are raised in a "hands-on" environment.

The latter involves keeping track of child
appropriate boundaries.

Glenn Williams, executive director of Focu
was the keynote speaker Tuesday at the Her

He also stressed the importance of family

Williams told the audience the most impo
ships with their children and maintain open c

ce of family in "drug pr

RCMP make $30-million ecstasy bust in Montreal

MONTREAL — Police in Montreal have seized more than 85
of the rave drug ecstasy in the largest drug raid of its

at Dorval Airport last Friday,

a popular hallucinogenic
has an estimated street v

Police decontaminate house after Winnipeg drug lab busted

WINNIPEG — Winnipeg police were still decontaminating a west-end house yesterday that doubled as a major ecstasy drug lab, only the second of its kind ever uncovered in Manitoba.

The unassuming two-storey house was raided by policy on Wednesday night. They clandestine drug lab they uncovered also produced GHB, which is known as the date rape drug, as well as the popular rave drug ecstacy.

A 33-year-old man was arrested at the scene.

The police drug unit was tipped off about the house by the vice department. Johnson said it was a fairly sophisticated operation

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